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ABSTRACT

In August, 1967, the Bedford program for School and Community Participation in Sex and Family Living Education received a Title III grant to create a Center for the Study of Sex and Family Living Education. The center organized an inservice teacher education program for Bedford teachers grade one through twelve. The inservice teacher education program was designed to afford the participants both a cognitive and affective learning experience. This pamphlet includes the lectures that formed the basis of the inservice course. Included in these lectures are: (1) "Sex Education from an Anthropological-Historical Perspective", by Albert A. Kahn; (2) "An Approach to Sex Education: The Fit to be Tied Program", by Donald E. McLean; (3) "A Protestant Minister Views Sex and Family Life Education", by Boardman Kathan; (4) "A Catholic Priest Views Sex and Family Life Education", by John McCall; (5) "Biological Foundations of Human Reproduction", by Ellison Pierce; (6) "Narcotics, Drug Addiction and Sex", by David Myerson; (7) "Smoking, Alcohol and Sex", by Henry Gurney; (8) "V.D. as Medical, Social and Sex Problems", by Nicholas Fiumara. The research reported herein was funded under Title III of the Elementary and Secondary Education Act. (Author/KJ)

Tips on Checks

talks to teachers

Published by the Center for the Study of Sex and Family Living Education, Title III ESEA Project, Bedford Public Schools, Bedford, Massachusetts as a service to school communities interested to develop programs in Sex and Family Living Education.

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PREFATORY NOTES

In the spring of 1963, the Family Living Committee of Bedford, Massachusetts, was formed under the auspices of the school administration. The membership represented the religious, social and educational institutions in the community.

The original purpose of the committee was to investigate the need for action in regard to a program which would educate the community to the rising incidence of venereal disease among teen-agers in Massachusetts in particular and in the country as a whole.

The committee soon recognized that venereal disease education involved a broader program in sex education; consequently, the members faced the problem of the school's specific responsibility in such a program, for sex education of children traditionally has been considered to be the responsibility of parents and church.

There was, however, growing awareness that many parents are unable to communicate successfully with their children about sex and related problems and responsibilities and that the churches do not necessarily contact all young people. The committee, therefore, investigated the possibility of the school's accepting responsibility for educating the public to the need for a Family Living program and thereby gaining acceptance for a program within the school curriculum.

As a result, a series of programs was presented to both the adult and school community, which highlighted the need for more extensive programs in the area of family living. The Bedford community was most receptive to the idea; therefore, subsequently a basic proposal for a triadic program, which involved the continuing Family Living education of the community, the faculty, and the students, was presented by the Family Living Committee to the school administration.

The school committee accepted the original proposal and, as a result, a curriculum guide was written during the summer of 1965 with the understanding that the course in Family Living would be incorporated within the existing school curriculum during the school year of 1965-1966.

It was understood that at the same time the Family Living Committee was to continue its activities in regard to adult community education with a concern to involve elementary school parents, while the school administration was to assume the responsibility for in-service teacher education to alert the faculty to their place in this aspect of the students' education.

During the academic year 1965-1966 a three-week unit on Sex and Family Living Education in the 7th grade General Science course and 10th grade Biology course was taught. The half year senior elective course was omitted from the curriculum because the teacher who had been designated to teach the course was on leave.

The courses were well received by all students and a majority of the parents. There was a small, but vocal minority group, however, that became very disturbed at the liberal attitudes that had been expressed in one of the biology classes. As a result of this discontent, the school committee voted to review the situation and withhold inclusion of the units within the curriculum until they had an opportunity to re-evaluate the total program.

The following academic year, 1966-1967, the 12th grade half year elective course was offered as originally written; the unit in the senior high school biology course was re-instated after provision had been made for establishing better methods of teacher supervision; and the 7th grade unit was re-written to provide for separate instruction of boys and girls and to delete some topics which had been opened for discussion in the original course curriculum. This was done primarily to eliminate areas that might be considered by the community to be controversial.

That year, prior to the initiation of the 7th grade and the senior high school biology units, the school administration sponsored open forums for parents of the community whose students were to be involved in the classes. Faculty, school committee members, and administration personnel served as panelists to acquaint the public with the course outlines that were to be used and to answer any questions relevant to the units in terms of underlying philosophy, methodology, and course content.

Many clergymen within the community, specifically those of the Catholic, Baptist, Congregational, Episcopal and Unitarian faiths, conducted concurrent programs for both young people and their parents within their congregations in order to answer theological questions that were raised by the school program.

The community as a whole received the program well. Even those who had been unalterably opposed to the school's involving itself in this aspect of student education, that which has traditionally been acknowledged to be the prerogative of the home and the church, seemed to accept it.

Subsequently, new hostility to the program came about in reaction to an article that was featured in the BOSTON SUNDAY GLOBE MAGAZINE. This article, though basically extremely favorable to the pilot program in Bedford, quite irresponsibly linked pictures and stories of school activities with those of a church group. As a result, many in the community resented the image that was imprinted on the minds of the reading public.

Since then, however, by carefully screening public relations, the situation has been corrected. In addition, the original Family Living Committee was re-organized to include a larger representation of parents. In this way, those directly responsible for the continuing success of the program gained a realistic consensus of the attitudes and feelings of the community.

In August of 1967, the Bedford program for School and Community Participation in Sex and Family Living Education received a Title III Elementary and Secondary Education Act grant from the Federal government, one of two in the entire country. This grant was given to create a Center for the Study of Sex and Family Living Education. The objectives of the Center include the following activities —

1. The establishment of a center for coordinating school and community activities in the area of Sex and Family Living Education to serve Bedford and other interested communities.
2. The extension of the present curriculum through grades one through twelve to make the subject matter of Sex and Family Living an integral part of students' educational experience in Bedford schools.
3. The establishment of a library of audio-visual aids, books, magazines, pamphlets and other source materials relating to the field of Sex and Family Living Education.
4. The continuation of a program of adult education so that parents can more readily further their children's education in areas of Sex and Family Living.
5. The continuation of a program of in-service education for teachers within the school system to help them gain an understanding of their responsibilities to the student in these vital areas of his education.
6. The ability to offer direction and guidance to communities interested to establish similar programs.

In 1967-1968 the Center, in cooperation with Dr. Carl Willgoose, Professor of Health Education, Boston University, organized an in-service teacher education program for Bedford teachers of grades one through twelve. This involved teachers from each grade in one elementary school and from each grade of the junior and senior high schools who had a commitment to the program and were interested to become involved.

These teachers who participated in the program are currently engaged in building curriculum units so that Bedford Schools, in the fall of 1969, will have a developmental program in Sex and Family Living Education in grades one through twelve.

The in-service teacher education program was designed to afford the participants both a cognitive and affective learning experience. The cognitive learning was effected by means of lectures, readings and films. The affective learning came as a result of the question periods which followed the lectures; discussions, that were stimulated by the lectures, reading, and films; and the sharing of ideas, attitudes, and feelings within the group.

This pamphlet includes the lectures that formed the basis of the in-service course.

The value of every person's having a thorough knowledge of the biological and physiological aspects of human reproduction, growth, and maturation in addition to an understanding of the psychological and social problems that the individual faces in our changing society cannot be underestimated. Then, too, the perceptions and insights the participant gains of himself, his attitudes, and his behavior through these learning experiences has great implications for his life as a responsible human being.

It is in the context of promoting this knowledge this pamphlet is offered to teachers. I am grateful to all of those whose participation in the program made this possible. I would also like to express my appreciation to Miss Frances Gardella, Resource Assistant to the Bedford Project, whose patience, eternal vigilance, and constant good-nature promoted the necessary activity.

ESTHER B. KAHN

Project Director, Center for the Study of Sex & Family Living Education

Bedford, Massachusetts, December 1968

SEX EDUCATION FROM AN ANTHROPOLOGICAL HISTORICAL PERSPECTIVE

ALBERT S. KAHN, D.ED.

I am interested in sex education and the education of teachers for teaching in the area of sex and family living education. What I would like to do is to offer you background from an historical perspective of sex education in schools and review some of the literature in anthropology which has given rise to some new conceptions of what sex education should be about. I am going to talk on three major topics.

First, I am going to suggest that an overview of contemporary culture demonstrates the need for sex education. We will look at the sources and at some of the reports from the various journals, cultural sciences, and see what they are saying about the contemporary state of affairs in American life. Next I shall discuss the importance of some kind of sex education in the schools. For this I will use some of the tools of the social scientists: history, anthropology, and philosophy of education to see if there is a way of organizing the practices in the teaching of sex and family living. Then, finally, I will review with you some of the current things which are being said about sex and family living education by various authorities.

I would like to say that the urgency for sex education became quite apparent to me last week when I received a notice in the mail from the University Council on Geriatrics of a series of four conferences which they were planning. The first one I attended was entitled, "Sex Over-Sixty." One of the most interesting bits that I got from this session was the fact that there is a great myth in our society about sex over sixty, and the sexual disability of older people. We have an idea that what is virility at twenty-five is lechery at sixty-five. Society coins its own myths about the nature of, or possibility of sex in adults of that age. A myth of this kind leads, I would say, to many kinds of frustration in family life. Someone at the conference said that if the bedroom isn't right, every other room in the house is wrong. Those who are interested in family living might well consider this aspect of successful family life.

It is obvious that we have these kinds of myths in our culture which need to be destroyed, and there is no way of doing it better than by recognizing the importance of sex education beginning at the earliest ages as you are doing here in Bedford, developing what will eventually be a K-12 program.

If we look further into our youth culture, we find a great change in attitudes of young people . . . teen-agers and college students . . . and their feelings about sexual behavior. I have in front of me a survey done in 1952 which was repeated in 1965. The question which was posed to groups of young people at that time was this: If I learned that some friends of mine had not followed the morals and rules relating to the

ALBERT S. KAHN, Ed.D., is Associate Professor in the Social Foundations of Education Department, School of Education, Boston University.

behavior of unmarried people but had broken the moral code that the community holds: 1) I would not consider them good friends anymore, 2) It would not make any difference in our friendship. In 1952, fifty-seven per cent of the young people said that if their friends broke the moral code, they would not be good friends anymore. They would disown them as good friends. In 1965, instead of fifty-seven per cent disavowing their friends, sixty-nine per cent said that it would not make any difference in their friendship. I think you can see this is a change in the value system youngsters hold today.

Young people today, furthermore, have what is called a "hang-loose" ethic. I don't know how familiar you may be with this term, but the "hang-loose" ethic is one that tells young people to disinvolve themselves from the social problems with which they are surrounded. They feel the adult generation has nothing to offer them. They lack the ability and they feel their parents lack the ability to engage in communication with them, and so they resort to a sort of privatism. They go steady at a very early age; they are apathetic about school, about work, and in general, create a very difficult and disturbing problem for those who are interested in their best interests and their maturation and their adult responsibilities. So we have a generation gap. The young are disengaged socially, economically, politically, academically, and culturally, in ways that are extremely disturbing to their parents.

To explain what I mean by this, I would like to tell a story. Recently a guidance counselor, a student of mine, brought four students from a local high school to talk to the class. The class was composed of people taking advanced degrees. They were in-service teachers like yourselves, and very mature. The four high school students came in to talk about drugs. What came out of their conversation at first was that this was the first time any adults had talked seriously with them about the use of drugs. People had said you mustn't do this; it's bad for you; you'll end up taking heroin; you'll have some kind of psychotic episode; you'll get sick. But nobody had ever actually discussed the problem with them. What they wanted and really needed was some good information, good knowledge, the best scientific data available. This they knew they didn't have because the information they did have was from reading an occasional acticle in a popular journal or in a newspaper. They also had learned by drawing inferences from observing their friends. They are intelligent people. They recognized that their information was not the best or even accurate, but they also recognized that the interdictions that were being hurled at them by their parents, theologians, or school teachers, etc., did not coincide with some of their observations. Many of their friends were taking marijuana quite regularly, or on occasion, but they didn't see the thunderbolt come down from heaven so they couldn't quite believe some of the things that had been told them.

They did, however, recognize that there was something about the whole drug scene that they ought to understand better, and for this they looked to adults for guidance; they looked to adults for discussion, but couldn't find either. They just didn't want to be told what to do. They

wanted to make up their own minds. They wanted to be autonomous in decision making. I think this is characteristic, and perhaps, those who are interested in the whole problem will agree with me, that young people want to make up their own minds. They don't want to be told what to do.

Now, the kinds of information upon which attitudes, beliefs, and understandings about sex and sexuality are based come from a variety of sources. Most of them, in fact, never take into account the wider psychological, and social implications of the behavior, or the problem. We find that our TV, our radio, our newspapers, our magazines, inundate young people and adults, too, with very fanciful romantic notions about sex. We are all aware of the cigarette ads that contain the subliminal suggestion that smoking cigarettes produces the "Marlboro Man," some kind of fantastical creature who doesn't really exist. We find this kind of thing in the movies, too. Wherever we go in our society we see the impressions created by the mass media.

Now it is true the mass media educate insofar as they help the people form attitudes, beliefs and understandings about themselves, their environment, their society, and their behavior. This kind of information is informal, extra-school education, and it can be extremely miseducating. Certainly then there is a place for an intelligently controlled kind of education such as can be acquired and developed in the public schools.

If you look further, you will see that another source of information about sex comes from sociological and biological studies such as those done by Kinsey and Masters. These studies are good studies for their purpose, but certainly the kind of public interpretation that is given them lacks the kind of insight and the kinds of answers to questions that young people are concerned with, and about which they need to have information. Similarly, at the other extreme, as an example of another type of miseducation is the kind of literature which may be good in itself, like Lady Chatterley's Lover, which is probably a very good novel. However, I would say that it would be entirely unexpected for young people to get ideas about sex and family living out of that novel. They couldn't get good ideas out of it. They would get very distorted singular kinds of notions about what sex and family living are about.

Recently there appeared in the JOURNAL OF SCHOOL HEALTH, an article I would like to recommend to you which was published in the May 1967 number. The paper contained an index done on the basis of the Kirkendall study which showed that the degree of guilt and reticence in discussing sex questions started at zero in the elementary grades; in other words, children have little, if any, reticence in kindergarten or at that age and it goes up very dramatically to reach a peak of almost complete reticence at the high school and college age, a peak which persists through adulthood. Certainly this kind of inability to discuss questions so vital to living and to having feelings of guilt about them when the questions are posed, or a discussion is held, is a very negative situation and does not speak well for the successful growth and maturation of an individual. By letting a child speak, we learn what he needs

to know. We mustn't just inundate him with information. We must give him an opportunity to express himself. Then we can help him to determine what his needs and interests may be.

Recently a study was made by some eminent sociologists that was published in THE JOURNAL OF SOCIAL ISSUES, April 1966, in a number devoted entirely to the topic: *A Sexual Renaissance in America.* I would like to briefly summarize for you some of the findings of these eminent sociologists on various aspects of sexual behavior in America today.

First, a permissive premarital tradition has taken root in American culture. You may not like it, but this is the finding of objective sociologists through their studies. Second, the mores seem to be shifting in the the direction of the Scandinavian type of sex standards. This is based on the association of sex with affection and emphasis is on the quality of the interpersonal relationships. It is not promiscuity, but it is a permissiveness when there is a correlated affection. This is what, I think, our young people seem to mean when they talk about a meaningful relationship. Third, this shift in attitudes is true of the female rather than the male. Males were apparently always permissive or promiscuous, as you will. The shift is also among Whites rather than Blacks and among upperclass women rather than lowerclass women. So it is an upperclass white female who is adopting this attitude of premarital sex with affection.

The actual incidence of sexual promiscuity, as the sociologists have determined it, reached its height around 1940. Since 1940, the quantity of frequency in America has not increased. But what has increased is a permissiveness and acceptance of this as a way of behavior. I think that this is corroborated by that other statistic that I quoted to you earlier about friendship and one's attitude toward those who had broken what was the moral code.

I would like to offer more statistics from studies done two years ago. Every year three hundred thousand brides are pregnant; three hundred thousand single girls have abortions; three hundred thousand single girls become unwed mothers. Less than thirty years ago, in 1940, the climate of the culture was such that the surgeon general of the United States was not allowed to use the word syphilis on the radio! It was better to be silent. A further survey indicated that it is the fundamental values and not information about contraception that are the determinants of choice of those who do not engage in premarital experience. In other words, eighty-nine per cent of those surveyed said that the reason for the refusal to do what they might otherwise have done was not that they didn't know about contraception, but rather that they had moral objections; forty-four per cent feared pregnancy, and fourteen percent feared venereal disease.

Again there is no evidence that information about contraceptive devices or the pill is in any way influential in increasing promiscuity. Principally, therefore, the problem is a moral one; in other words, young people are making choices about their behavior and they are re-

evaluating the traditional sanctions. I do believe that the move toward sex education in the public schools reflects the adult concern about the lack of factual information. It also reflects the fact that schools have neglected social science information in general, particularly, that which bears on sex. Consequently, in light of the goals of sex education, it well may be better to build broad social science course materials at all grade levels which would include sex education.

I would like to end this section by referring you to something I read the other day in Walter Lippmann's column in the BOSTON GLOBE, Wednesday, October 4, 1967, in which he talked about political isolations. He wrote that people aren't interested in politics today. There has been a turning toward private affairs. He says that one of the major reasons for this is that people everywhere are very preoccupied with the problems, pains, and pleasures which confront them because they are living in the midst of the most radical revolution in the history of mankind. This revolution is a transformation of the human environment and of man himself by technological progress which, beginning about two centuries ago, has now acquired enormous momentum. It is changing the way men live; not only their work, their homes, their food, their communications, and their pleasures, but it is changing also the structure of the human family and the chemistry of the human personality. These changes are bewildering; they are frightening! These are the kinds of changes that are going on, and I would submit to you that unless we take this into account, we can't begin to understand what is going on in the minds, feelings, and hearts of young people; and why the kind of commitment you are making towards sex education including, particularly, the concept of sexuality and human behavior, is quite appropriate. There is no other way, I think, by which we can come to grips with this change unless we just engage in a kind of obscurantism, and silence ourselves out of fear. This is probably the worst thing we can do because all the evidence points to the fact that without education in this field, there can be nothing but retrogression and exacerbation of our present ills.

To develop some ideas about how to proceed with the problem of sex and family living education, to what kind of sources can a teacher refer? For this, I would like to use a few sources in the social sciences: history, anthropology, and the history and philosophy of education. What I want to do is to take four concepts and show you two sides to each one of these concepts. One of these concepts would be what I would call a traditional point of view; the other, a contemporary emerging point of view, because it doesn't have a final form. The final form doesn't exist; it isn't out there someplace waiting to be discovered. Nobody has "the word." It is something that you, as teachers, will have to create. This is why, I think, the pattern of your program here at Bedford is particularly admirable, for the teachers following in-service education are then going to create the program. You can't have an authority-figure create it for you. Since you have to teach it, it must be yours, and it wouldn't be worth anything if it were something that came

from some superior source; for example, some academician. In too many places, communities are looking for ready-made curricula, and I would say that these are doomed to failure because teachers can never teach what isn't in their own hearts, feelings, and interests.

Let me suggest a few ideas to you. If we go back to around nineteen hundred, we find that in the first period of this century, about the first ten years, there began to emerge a concern for sex education in the schools, but no one did anything about it. People talked about it, particularly because there was at that time a high incidence of venereal disease and at the same time rampant prostitution. Government officials and national organizations were very much concerned for the health of the nation. Consequently, the leaders instituted meetings and discussions in various organizations to talk about the need for sex education in the schools. These people were interested in social control. They discussed, for example, the ideas that were being used for social control, particularly, in Europe. So in 1909, the NATIONAL SOCIETY FOR THE SCIENTIFIC STUDY OF EDUCATION, an outstanding journal, devoted its whole yearbook to sex education in the schools. They suggested that sex education was necessary if the nation was going to control these evils of venereal disease and prostitution. Today, prostitution is not so common and venereal disease comes not from prostitutes but from women who are not so classified. (I think that Dr. Fiumara has some very interesting statistics on that.) In any event, in Europe, in 1909, there were three methods of controlling the black plague — venereal disease and prostitution. One taken from France was called réglementation which meant state regulation of houses of prostitution. The French felt that through supervision and control of prostitutes the incidence of venereal disease would be minimized. A second idea was that stringent legal and police measures be taken to eliminate prostitution. A third idea was called a policy of moral regulation. This encouraged various kinds of repressive measures to reduce solicitation, to remove children from the homes of bad parents, to engage in supervision and purification of the medical profession to eliminate quacks, to provide industrial education for working girls, to have juvenile courts, to control employment bureaus. In these three ways nations of Europe met the problems. America rejected these methods saying that what we needed to combat these problems was education in the schools.

In the twenties, just after World War I, the federal government financed conferences at schools and colleges to devise programs which might be used in the schools. Syllabi were created, pamphlets and aids for teachers were distributed, but still there were very few, if any, experimental attempts at education in the schools. As we come into the thirties, we find that some of these programs were instituted. Some non-governmental groups, for the first time, added the idea of family living and sexual adjustment. Most of the interest, however, was in transmitting factual information about reproduction and venereal disease, oriented principally, probably, to creating an atmosphere of fear: the dire consequences which might follow if one acquired a

disease through breaking the moral code. Gradually though, this limited perspective began to be expanded, and programs experimented with ideas of personal adjustment and human relations. Now, you are adding the concepts of sexuality, human growth and development in terms of physical, psychological and social changes.

At this point it might be interesting to take a look at some sources in anthropology to help us determine from where our values and ideas about sexual behavior came, i.e., the role of the male and female in society, what society expects of them, what society will accept and encourage, what society will reject, and what it will discourage. These standards are very important for young people because these provide the models toward which they can aspire or which they may reject. Today, particularly, we have a great deal of confusion about these roles. This confusion, perhaps, is intensified by the changing society in which we live. All of this can be very threatening. But the anthropologists have taken a different tack by recognizing that the roles are determined by society. They are not inherent in the biology of male or female. What it is to be a male does not necessarily coincide with man; what it is to be a female does not necessarily coincide with woman. Margaret Mead in a book called SEX AND TEMPERAMENT . . . using the word "temperament" as personality . . . examined three different primitive cultures. In these three different cultures . . . the Arapesh, the Mundugumor and the Tchambuli . . . Miss Mead examined the relationships between male and female for such kinds of mental postures as subservience, passivity, acceptance, dominance, management, because our notion, it may be myth, seems to be that the man is the leader, the aggressor, the dominant person while the woman is the accepting, soft, affective person. In our society, when this value system is breached, there is some feeling of discomfort and a feeling, perhaps, that the other person is wrong, is acting in an unnatural way. In other words, the individual would be acting in a manner contrary to his biologically determined nature.

Now, the anthropologists find that this need not be so at all. Among the Arapesh men and women were culturally conditioned to behave according to what we would call the female syndrome; that is to say, both men and women were soft, accepting, kind, affectionate, passive people. This was the value system for behavior among the Arapesh, and anybody who transgressed these values was considered to be a deviant. In the next society that Dr. Mead studied, the codes were exactly the reverse: both men and women were aggressive, demanding, ruthless, and positively oriented. The third tribe, the Tchambuli, was one in which our model for the male and female was completely reversed. In this tribe the woman was the dominant, the impersonal, the managing, the aggressive one, in every way, sexually and otherwise; the man was quieter, more responsive, emotionally dependent. In other words, the conclusion that anthropologists have come to is that there is no basis in sex itself for the notion that there are sex-linked roles. What men and women can do, they can do as persons. In my own experience, I note

that there has been a great cultural value change toward playing tennis. When I was a youngster playing at the playground, truck drivers would come by and, regarding tennis as a feminine game, would call out, "Forty love!" I remember when our team at Boston Latin School won the City of Boston Championship. We beat English High School in the finals, and our headmaster, Pat Campbell, was so happy with us he gave us letters. Now the tennis team had never got letters before. So we got "L's" and, boy, I got my sweater and put that "L" on it. The next day I came to school and one of the football players nearly killed me: What was a tennis player doing with a letter? Tennis was a sissy's game! This attitude has changed today, of course, as it has in regard to many other activities.

I suggest that in addition to these insights that we get from the history of sex education and from anthropologists, we find that as teachers we must distinguish between what I would call special education and general education. Special education is that education that is oriented to the particular needs of individuals; general education is oriented toward social learnings. Social learnings are the kinds of learnings that we need to acquire in order to live with each other in a common society.

It has been said that the school is a place where shared experiences can be had by people. Now, certainly if our young people are going to live together in the community, they are going to find sexual partners there, and they are going to establish as community people. No moral code or value system is going to be imposed upon them as much as we as adults might like to do it. Therefore, the quicker they can learn to talk about these social problems together and to explore their feelings and ideas, thereby eliminating misconceptions and myths, the healthier are the solutions going to be.

I would submit to you that this is possible only in a general education situation. We know now, for example, that the school of the future is going to emphasize more and more social learnings and fewer special learnings because these will be done by mechanical means better perhaps than some teachers can do them today.

I would like to conclude with a few findings about sex education and the family. I happen to have read a book called SEX EDUCATION IN THE FAMILY by Father Francis Filas, a Jesuit priest. He says that sex education is not sex information. This is consistent with that which I have indicated. Sex education is that type of education which relates to the fullest development of the person. Later, in the book, Father Filas cites some popular objections to sex education in the schools. He says, for example, one objection is that sex education will lead to promiscuous intercourse. In response he asks, "Will the absence of sex education reduce it?" A second objection is, "There is too much talk about sex, the less said, the better." But he says that the assumption here is that sex is dirty. Pornography is not sex education. We have a great deal of good information about sex. A third objection is, "Our parents didn't have sex education, why should we?" Then he adds, "How well did they get along? Do they have healthy attitudes?" A fourth

objection is that the schools don't have to become involved for young people will get the information elsewhere. Father Filas asks, "Where?"

The literature that I have been able to look at seems to support very much the point of view that you have initiated for your discussion. You, as teachers, have the responsibility and the opportunity to create your own program in the light of your own understandings and your own commitments.

AN APPROACH TO SEX EDUCATION: THE FIT-TO-BE-TIED PROGRAM

DONALD E. McLEAN, M.D.

I would like to explore with you today a subject of deep concern to all responsible parents and teachers. I want to consider the broad field of immunity as it relates to our children, for we must immunize and inoculate them against the frightening advances of the disease which we shall investigate this afternoon. Before attempting protection against any condition, it is vital to define the offender as to its area of incidence, whether or not it is pandemic, worldwide; or endemic, local; the attack rate; who is attacked; what percentage of the population is involved; the severity of the disease; how incapacitating the disease is; and the age and sex of the specific group involved.

When it has been determined that an offender is dangerous, is widespread, and is showing a marked increase in pack rate, then an energetic immunity program is clearly indicated to protect susceptibles. We do have an offender that answers all the necessary requirements as just stated, and an immunity program is urgently needed that demands the enthusiastic support and action of all of us. It is vital that our children be effectively treated so that they may have the antibodies necessary to successfully protect them against the onslaughts of this offender.

Now the disease process under consideration is particularly dangerous and deceptive. It may be called the great imposter for it gains entrance into innocent homes in many different ways. It is not a clear-cut pathologic entity such as measles, pneumonia, and arthritis; but rather more of a cancer, a social cancer, a wide-spread malignancy, with a variety of signs and symptoms. It has recently been referred to in the press as a sex revolution or liberalization of sexual behavior. Whatever it may be called, it portends greater tragedy if its forward progress is not checked.

Sex education has become one of the most depressing public health concerns of the day. Enlightened public officials and intelligent and concerned parents realize that the growing-up processes today are far different from those of years ago. The pace is much faster; temptations which are greater and more numerous confront young people when they are at a more unstable age. Accompanying the ever-changing mores is a dramatic and terrifying increase in the use and abuse of the hallucinatory, excitatory and soporific drugs, and alcohol. Coupled with the use of these and other harmful products, there has been a concomitant decrease in the age of the user. Unfortunately, but effectively, these factors lead to more sex experimentation and promiscuity, and it is also true that the alcohol consumption which ten years ago we did not worry about except in high school, we now worry about in junior high school or even in grade school. The problem is increased, for the lower the age the less control the individual has over his emotional and psychological reactions; therefore, the difficulties really begin to multiply.

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In our extensive care unit, we recently have had several fourteen-year-old youngsters who have been so smashed on alcohol that we have been concerned as to whether they'd make it or not. They drink vodka with orange juice and being very impatient to have the immediate effect, swill it down in such large quantities that by the time it hits, they are about in the third stage of anaesthesia.

The sex revolution is not just an American concern; it is pandemic or worldwide. The following official figures illustrate the intensity of our own national problem. Last year there were 300,000 unwed mothers of whom one-half were between the ages of 13 and 19. I imagine the age would be less than 13, but most girls can't conceive below that age. One-quarter of these unwed mothers are on public welfare, i.e., they have become wards of the public. There are over 500,000 cases of V.D. among teen-agers in this country: a colossal number which has been spiraling in the last ten years. In addition, there were an estimated 1,300,000 abortions. The first two figures are absolute. Of course, the abortion figure has to be an estimate. It may be a great deal more that 1,300,000.

The object of our concern is the teen-ager who compounds the difficulty because this is the great iconoclastic period of his life. At no time is it of greater importance for parents and children to maintain good, clear communications yet, ironically, at no time are these relations poorer. Because of the impatience on both sides, and the impetuousity of youth which is so disturbing to the adults, it is particularly difficult to relate to one another. That is why the successful training of a teen-ager in all categories starts at birth.

The following peculiar traits make the teen-ager a prime target for the socio-sexual problems that we are going to discuss: 1) It is the age of the greatest sex drive coupled with the least control and the poorest judgement; 2) It is the age that least accepts parental suggestions and controls; the age that has the greatest need to conform to the peer group and the least desire to be an individual or non-conformist; 3) It is the age that has the least fear and also has the least knowledge of consequences; 4) It is the age of the greatest exodus from the home and its control . . . they go to college, they go to work, they go into the Army; 5) It is also the age when the need for kicks is greatest or the fear of being "chicken" is greatest and more meaningful.

We realize that the final solution has got to be the establishment of closer bonds between parents, greater understanding and communication among parents and children, and instruction of children from birth. There must also be a cooperative relationship with the schools and, when indicated, with the churches and the medical profession. We must adopt team methods in every sense of the word.

The type of sexual education program that we just completed in Woburn was most encouraging. It consisted of four sessions and included 500 youngsters. In fact, we had to turn away 100 youngsters because logistically we just did not have the space. Nowhere in the past 12 years of doing this type of work have I witnessed a greater or more enthusiastic response.

But what about all the non-church youths who are not likely to be exposed to these programs? In the final analysis, the most effective method must originate in the school system with considerably more homework being done by the parents before and after the school program begins. The church and the medical programs may always be used to supplement and to strengthen a basic existing school course.

Let us turn to the role that is played by the family. First, our judgment is only as good as our information. Children will learn about the facts of life one way or another: either from a healthy authoritative source such as the family, the school, physicians, church or via the amateur professors, their peers. The most dangerous attitude for a parent to take is that of the ostrich . . . the non-existence of a need that is obvious.

Second, sex is not something we do but something we are. A child learns more about sex by living in an atmosphere of love and a happy marriage where there is a respectful concern for each parent's wishes by the other parent. This positive sense of sex morality permeates all happy well-adjusted marriages and is absorded intuitively by the children.

Questions from children are seldom, if ever, complex nor do they require long and involved answers. The answers should be direct when referring to parts of the body. Correct anatomical nomenclature should be used and substitutes avoided. If you feel you have given your child an answer to any question that might disturb your neighbors, you should caution the child that he should not inform all his friends of his new-found knowledge because this is the job of his friend's mother and father, not his. Incidentally, this is where we do get into some difficulty with the advanced student in this subject. In many neighborhoods there is the feeling still to say nothing and, of course, the child who is well-informed becomes persona non grata in certain homes unless he is warned that he should not spread the word.

Books that are helpful are many. I am just going to mention the one that we asked to have our local bookstore keep on hand: the Dutton Sex Series by Lerrigo and Southern. It is divided into five different books dealing with ages 3-8, 9-12, 12-15, 15-20, and the adult age.

The ideal school system begins sex education at grade one and is best exemplified by the Evanston School System under Superintendent Shute. It has been in effect for ten years and is called Family Living rather than sex education. For some reason or other, the words "sex education" bother a number of people. I don't know why they should; it is sex education. Some people are happier to have the subject called Family Living. If they do, I think it's perfectly all right to call it Family Living.

During the early years, the simple anatomical facts are gradually introduced and then during the teen years the socio-sexual problems, dating, etc. are discussed. The most important ingredient to successful school instruction is the training of an adequate corps of teachers who relate well to young people and who are enthusiastic about the need for such instruction. Those who are going to present the program should be educated in the subject. I think the lack of teacher education has been

one of the big problems with the Swedish program in sex education. The Swedish people made sex education mandatory and then anyone, even if he were adverse to teaching the program was told he had to. Here they lost much of the enthusiasm which many of the teachers might have had for the subject. Obviously, the students who had a teacher who was not enthusiastic gained very little information.

It is my firm belief that it is a privilege as well as an obligation for parents to impart sex education to their children. Schools, churches and men in the medical profession can help the parents impart their ideals and beliefs. These agencies neither intend nor wish to usurp the obligation of the family. However, one must be sensitive to the difficulty a parent has talking to his child about matters sexual. The mother is usually very good; the father, unfortunately, is the one who falls down. During my years as a pediatrician, I have encountered this situation frequently. A mother will say, "I think Johnnie has become old enough to learn about the facts of life, but talking to John, Sr., he says, 'Why don't you have the doctor do it?'" This, I think, is a fine idea but I just can't reach every child though I have tried to develop a method. I have gone through the process of having a child come to the office to try to tell him the facts of life. He blushes and is obviously hearing nothing. I have tried turning in my chair and talking to the wall so that Johnnie won't have to look at me. I have tried going to Johnnie's house but having the parents leave. This is still a confrontation. One method I have found that is quite successful is to use the automobile. When it comes about dusk, I drop around to pick up Johnnie, who is coming along to keep me company while I make some calls. I turn the panel lights off so I cannot see whether or not he is embarrassed and I drive. He knows I can't look at him. Then I tell Johnnie the facts of life as I think he should have them. If he has any questions to ask me afterwards, fine. Johnnie stays with me until I feel he has been told everything I think Johnnie should know. The only reason I know that this way is a success is that it is the only time a child will stop and say, "Thank you." If he does that, I know that he has been listening. Another way I know the meeting has been successful is that he doesn't run out of the car; he's not in a panic. You must remember that most young people have been grought up to believe that sex is a bad subject. If it can be made an understandable, intelligible part of their lives, then we have a success story. When a youngster gets out of the car and says, "Thank you, Dr. McLean," then I know that something good has happened.

All too often sex education is considered to be a matter of transmitting facts with no moral overtones. To discuss sex without regard to morality is similar to instructing a class in automechanics without any regard to controlling the engine. The sex drive that motivates us is one of the strongest and one of the most awesome of all the directional forces that we are subject to. It is responsible for the most wonderful and meaningful relations in humans, and, at the same time, it is responsible for the most vicious and violent crimes committed by man against his fellow humans. The understanding and control of this

force may well be likened to the understanding and control of fire. Contained and controlled, fire is a source of comfort, warmth, strength and protection; without a control, it becomes murder, vicious and capable of causing wholesale chaos and misery. The same may be said for unbridled sex power on the rampage.

To give a lasting meaning, a working formula to live by, there must be a discussion of sexual morality. Sexual morality should be no different from any other morality. It, too, depends upon definite rules of performance and behavior, and these rules demand integrity and honesty in our relations in dealing with others. Sexual morality calls for consideration of the welfare and feelings of the other individual to be placed above personal desire. Sexual morality abhors the use of another person as a thing simply to satisfy one's appetite and then to discard. It also does not tolerate a compromise with conscience to the convenience of the moment. If we demand certain specific ethics in our social, community, and business relations, we certainly must not settle for anything less in our close interpersonal relationships. This I feel very strongly about. To teach sex without having its real meaning imparted to youth is to teach a purely factual course in anatomy.

Twelve years ago I became involved in sex education because the Episcopal minister at our church, a wonderful man who has since died, realized how badly youth needed information. He asked many of us in the parish if we would assist him in the first "Fit-To-Be-Tied" programs. This program is divided into four parts. The reason it is not applicable to an entire city is that we have so many non-church going youngsters. We have done these programs ecumenically so that we can reach the Jewish, the Protestant and the Roman Catholic communities. This, however, leaves a tremendous group who will never be reached. Consequently, the schools have a responsibility.

"Fit-To-Be-Tied" has some points I'd like to tell you about. One, it is divided into four separate sessions; five, if you include the session we have with the parents. (I sometimes think that this is the most important session of all for it is surprising how little parents know.) The first session, which involves young people in grades 9 through 12 consists of showing films on human reproduction simply to have a base line so that they all will have common knowledge of spermatogenesis, menstruation, and conception. At this session the young people are asked . . . and I think this is the heart of the "Fit-To-Be-Tied" program . . . to write any question they care to about sex in any level of their living, but they are not to sign their names, just their age and their sex. The questions are then categorized in respect to age and sex so that when the doctors meet with a specific group, for example, ninth grade boys, they answer the questions ninth grade boys had asked. The questions are really eye openers! The young people do trust us. The five categories that invariably appear for discussion are homosexuality, masturbation, pre-marital sex, venereal disease, and birth control.

At the second session a psychologist talks about the socio-sexual problems. The third session is turned over to physicians who meet with

groups of fifteen or twenty to answer the questions turned in at the end of the first session. Answering these questions opens Pandora's box. It is then the physician has a very rewarding experience for there develops an honest give-and -take. The fourth session is the one in which the rabbi, minister or priest meets with his own young people to tell them the real meaning of love and marriage. "Fit-To-Be-Tied" also opens the door to the young people in the community to meet with the clergy or physicians at any time after the program to help them if they are in any difficulty.

A PROTESTANT MINISTER VIEWS SEX AND FAMILY LIFE EDUCATION

REVEREND BOARDMAN KATHAN

As a participant in an in-service teacher education program, I am wearing two hats: one as an ordained Protestant minister; the other as chairman of the Massachusetts Council on Family Life. The purpose of the Council is to provide opportunities for organizations or individuals in the Commonwealth interested in family life and marriage, to exchange information and ideas, to discuss matters of mutual concern, and to stimulate education, counselling, research and legislation designed to strengthen family life education.

I intend to discuss four ideas in this presentation. I want to begin with my philosophy of family life education. Then I will discuss the essential and desirable qualities about a teacher or leader in such a program of sex education. This will be followed by a brief word about the need for sex education. Finally, I will speak about the place of the Church and the Protestant minister in this field.

My approach to family life education is, of course, part of my overall approach to education, which is the growth and nurture of persons within a community in such a way that they will realize their potential as persons, find a place for themselves in relation to others, and make a contribution to the on-going life of their world. This kind of education does not happen in a vacuum, but rather within a community of scholars, of persons, of citizens, of believers, or in terms of our churches, of people of God. Education is not indoctrination but rather an invitation to persons to share in a pilgrimage where there is a common vision or goal and where each individual person is unique and must make his own path guided by the experience of others. Education is not brainwashing but is a democratic process of seeking out truth in an open forum. Education is not just a one-way street, as all of us as teachers realize, but rather a mutual sharing and involvement where teacher learns from pupil as well as pupil from teacher.

In this context family life or family living education is the process of living in a family where each individual is accepted as a person of worth who can make a contribution to this network of kin relationships. Family life education is a life-long process, from preparation for childbirth to preparation for death, from infancy to old age. The curriculum of family life education, in the very broadest sense, is the course which all of us run through life. What we learn from these experiences depends upon the guidance which we receive. This is why I feel that family life and sex education should be related to all of our formal studies from nursery school and kindergarten through senior high school and higher education. This is why it should be a part of continuing education for adults. We all grow up and live in some kind of family structure, and

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yet this is something that we too often take for granted. Often we look upon the home and family as the woman's responsibility, and we fail to to see that both men and women need training for this essential part of life. Also, we need to see family living education as part of the broader field of human relations . . . the understanding of oneself and one's relationships to others and the way in which one gets along with other persons individually and in a group.

Sex education is an important part of family life education. It is also a life-long process. We are sexual beings from the time we are born until the time we die. Sexuality is an intrinsic part of our total personality. Education in sexuality, as Dr. Mary Calderone has reminded us again and again, begins at birth; we begin to learn about ourselves and our world through touch, taste, sight, smell, and sound. It is through the process of acculturation that we pick up attitudes about ourselves and our bodies. Sex education is going on all the time within the family, for good or for ill, positively or negatively. Dr. Calderone told a community meeting in Newton that a great deal of sex education, much of it negative, has gone on before the child even enters kindergarten. What we do in public school involves a process of remedial sex education. Honesty, respect for the truth, awareness of age-level development and openness to questions are as important in sex education as in any other kind of education. Biological and physiological knowledge help one to understand bodily changes and the whole reproductive process. Scientific data need to be related to the questions raised about masturbation and homosexuality, birth control, and other areas of concern. Sex education in our schools can be related to courses in science, social studies, English, home economics, health and physical education. In the senior high school and at the adult level there is a need for courses and programs in sex, love, marriage and family life.

In all that we do value systems will be communicated, but it is essential that we look at the different schools of thought, the different value systems in our society. It is at this point that churches and synagogues can complement and supplement the work of the school in presenting their particular religious value systems.

I would suggest the following essential qualities that a teacher in a program of sex education should have:

First, a teacher should have self- acceptance. It seems to me that the basic quality of such a teacher is love and acceptance of one's own self just as one is, excluding both complacency and self-rejection. This means acceptance of oneself as a sexual being, not a disembodied spirit; not just a rational thinking being from the head up, but rather as a person with a defined and conditioned sex role, sex drives, needs and interests. The teacher needs to be comfortable with his maleness or femaleness without apology, defensiveness, or over-compensation.

Second, a teacher should have the quality of self-understanding. It is essential for the teacher to understand himself and his reason for teaching. This is true no matter what the subject is, but it is

particularly crucial in the area of family living and sex which, in our culture, is so fraught with guilts, prejudices, stereotypes and all kinds of "hang-ups." The teacher needs to come to grips with his own sexuality and resolve the fears and anxieties he may have regarding the issues in the area of sexuality. The search for meaning and the problem of anxiety are certainly magnified at this point and self-understanding is essential.

Third, a teacher needs objectivity. It is essential that the teacher be free of embarrassment about sex and be able to approach the topic with critical intelligence and respect for the truth. This means that the teacher should not be shocked by words that are used, questions that are raised, or experiences that are related. This does not mean that a teacher is without a value system or deep feelings but rather that he does not seek to impose these upon students.

Fourth, a teacher should possess sensitivity. If a teacher is truly authentic and self-accepting, he will relate to others in a warm, outgoing, non-judgmental way. If he has truly faced himself, his feelings and motivations, he will not seek to manipulate, use, dominate, or coerce students. He will accept them as they are and recognize that his attitudes toward them are communicated not only verbally but also non-verbally through gestures, facial expressions, tone of voice and the like. He will also be aware of the way his sexuality always affects his relationships with his pupils.

Fifth, a teacher needs to have conviction. It is not contradictory to say that a teacher should have the quality of objectivity about sex at the same time he possesses a sense of conviction, or a value system. Objectivity permits the teacher and the pupils to look at both sides of an issue, but convictions enable him to take a stand when appropriate. When asked to share his own value system, he does it without pretending that it is the only "right" one, or "correct" one.

These are essential qualities, but there are other ingredients that are important for a successful program which have to do with the content of the subject matter, methodology, and technical skills. This is what you, as teachers, are involved in with these workshops and it involves an understanding of human development and growth. Certainly, too, a knowledge of the biology and sociology of sex and training in education methods is important. Then there are several important aspects that I would add: a willingness on the part of the teacher to participate in community life, meet with parents, help in development of curriculum, and so on. Further education is necessary through workshops like this, professional meetings, summer school, etc. All of these contribute to an awareness of current trends and developments in the field. Finally, I feel the teacher needs good experience in family life. I would be less than honest with myself if I did not add this as a desirable quality, although I do not feel that it is necessary for a teacher to be married if he or she is teaching a family life education or sex education course. Sometimes we hear parents say that they do not want anyone to teach in this area

unless he is married. I regard it as helpful for a person to participate with satisfaction in either a family or a larger kin relationship in many ways, but I do not think we should make membership in the nuclear American family club a kind of requirement or prerequisite for our teachers.

I promised next to say something about the need for sex education. In a recent issue of the journal *The Family Coordinator* there is an excellent article by Gordon Shipman on "The Psychodynamics of Sex Education." He has spelled out some factors which indicate how difficult it is for parents to carry out the task of family life or sex education in the home. He refers to the incest taboo, for example. Dr. David Mace feels that one of the problems between parents and children is caused by a deep-seated emotional barrier that perhaps we ought not to try to overcome by getting into deep sexual conversation with our teenagers. Dr. Mace suggests a reason why there seems to be this communication gap between parents and youths particularly in the area of sex. In a speech to the Massachusetts Council on Family Life he said, "I've come to the opinion that there exists a protective psychological mechanism, distinctly linked perhaps with the incest taboo, which makes it very difficult and, indeed, undesirable for parents to communicate at too personal a level with their teenagers in the area of sex. I think perhaps we may be flying against that at our peril. We have to work out the meaning of this in terms of what then we ought to do about sex education."

In his article, Mr. Shipman wrote about the need for privacy on the part of each indivilual in the family and also the factor of the mutual denial of personal sexuality of both parents and children. There is a stereotype which still is being passed on today: that children, particularly young children, are not sexual beings, and are not involved at all in any area of sexuality. The stereotype on the part of young people is that their parents are not sexual beings. Even college students find it very difficult to think of their parents as lovers in the sense of expressing their love through sexual intercourse. So, these factors, along with others, point to the real difficulty parents have in communicating with their children about sexuality. As Shipman points out, much that goes under the name of sex education in the home is only reproductive education, and perhaps the only place where it really succeeds is in the mother-daughter relationship, answering the questions as to where babies come from, and in preparing a daughter for menstruation.

Now, at this point, we come to the place of the Church in family life and sex education. Sociologists tell us that the Church is one of the motivational systems surrounding the family. The nuclear family — mother, father, children — is related to a number of organizations which have motivational primacy; i.e., they concentrate on socialization, on education or tension management. These organizations include the school, church, the doctor-patient relationship, etc. The Church serves to provide the crucial rites-of-passage for the family. Our religious institutions, through rites of baptism, confirmation or first communion, bar

mitzvah, wedding, or funeral, provide passage through the entire life of an individual. Religious institutions also provide for socialization: some form of educational instruction to transmit the religious heritage of the past to the new generation. Also, sociologists say the Church is important in terms of tension management, particularly, in relation to the emotional equilibrium of the wife.

In the past, the Church has played an important role in sex education by extolling the importance of chastity and the importance of obedience to parents. The Christian religion, particularly, has given peculiar merit to chastity, and the Protestant churches in the past have demanded high chastity for men as well as for women. The Sunday School in our churches has been accepted by most middle-class-oriented families as a kind of obligation as something you do even though there exist no conscious religious convictions on the part of the parents. The Church and its Sunday School have served to reinforce parental dominance and authority over children. This is the reason some parents do not attend but send their children. They perceive the purpose of religious education to be reinforcement and support of the control and authority of parents. This situation sets up a dilemma for the Church because young people, when they reach adolescence, reject and rebel against this kind of control and authority. Often they rebel or drop out of the Church or the religious institution because it is so closely associated with other kinds of authority in their lives. Yet the Church has an unique ministry . . . an unique place and role in this field of family life and sex education because, unlike the school, it ministers to the entire family through its worship, through its activities, through its life. It has greater access to the family in terms of calling and counselling. It is supposed to provide a program of socialization or education from birth to death. It provides the rites-of-passage, which I have already mentioned, particularly, in the area of preparation for marriage and pre-marital counselling. It is in this area that the churches have probably engaged in sex education more than in any other. The Church provides other significant adults to whom young people can relate as leaders, as counsellors, as advisers, as teachers, for often the young are not able to share some of their concerns with parents to whom they are so emotionally attached. Finally, the Church and religious institutions provide a parent-youth dialogue because of the nature of the religious community which transcends all age barriers.

How is the Protestant minister responding to the need for sex education? I'd like to report several things that have happened. First of all, Professor Joseph Burroughs of the University of Massachusetts conducted a six-week seminar in 1967 on sex education at the University branch in Boston. There wasn't a single clergyman among 170 participants which included teachers, nurses, doctors, psychiatrists, educators, social workers, etc. Questions were raised by Professor Burroughs: "Why . . . what did I do wrong? Why did no clergyman respond to this kind of program?" I talked this over with some clergymen and came up with some reasons: clergymen feel they just do not have the time to commit themselves to

this kind of series, or they do not feel it is their job. They like to turn this problem over to the experts, to the medical doctors, or to the family life educators who are skilled in this field. They feel that perhaps their role is pre-marital counselling or dealing only with the biblical or theological understanding of sex, the sacramental significance of marriage. Among our clergymen there is still the underlying feeling that sex is something one does not talk about: it just does not seem to belong to the Church and to the work of the ministry.

Let me also report on a study carried out by a group of people called Clergymen for the Advancement of Sex Education. This is a group of clergymen who meet three times a year at the YMCA in Boston. This group sent out a questionnaire this past year to 1,800 Protestant clergymen across the State. The results are very interesting. They received 670 returns. The questionnaire raised some of the following questions: 1) Do you have pre-marital counselling? 630 said Yes; only 30 said No. 2) Do you deal with sexual union in your counselling? 436 said Yes; 163 said No; there was no response from 41. 3) Where is the place of sex education . . . the home, the school, church-school, etc.? The largest number, 636, thought it should be in the home, but there were 530 of the clergymen who also thought it should be in the school and 487 who thought that it should be in the church-school. 4) Do you have a sex education program in your church? 397 said Yes; 252 said No. 5) Would you attend a seminar, workshop, institute, or meeting in the area of sex education? 322 said Yes and 98 said No; 250 said Maybe. This survey indicated that there was real interest on the part of the clergy. However, in the past, Protestant clergymen, especially, to fulfill this obligation in this area have handed out a leaflet or booklet and then felt their job had been done. Today, some churches participate in the "Fit-To-Be-Tied" program in the community. Some ministers are beginning to use some of the insights of the social sciences, i.e., marriage prediction scales and self-knowledge inventories, etc. But there is still too much preaching or moralizing in this field.

What we need to do also is to look carefully at the value systems and the whole area of morality and ethical decision making. We do not have the time to do this today, but I can mention that there is a wide spectrum of value systems in our society today. There are clergymen who take different points of view in regard to sexual ethics and moral decision making. These points of view vary from the most repressive to the most permissive approach. But we need to recognize in our society different patterns of behavior. In addition to the old single standard and the double standard of behavior, we are now moving more in the direction of "permissiveness with affection" as Dr. Ira Reiss has discovered. By permissiveness with affection, Dr. Reiss does not mean promiscuity. It is, rather, a recognition on the part of young adults today that the important thing is the relationship between two persons. We need a lot more research in this area. We need to recognize that a code of ethical decision-making needs to be developed for all areas of life not just the sexual. We make a real mistake to talk about morality . . . morals . . .

always in relationship to sex and sexuality. We need to involve young people in planning and evaluation for this kind of program of sexuality and ethics. Only then will our institutions, church, school, and synagogue, supplement each other in developing a program of family living and sex education.

A CATHOLIC PRIEST VIEWS SEX AND FAMILY LIFE EDUCATION

REVEREND JOHN McCALL, PH.D.

I imagine that some of you think it rather strange that a celibate would be speaking on the subject of sex and religion. This reminds me of a story of a priest who was giving a mission who devoted the whole time to marriage. On the way out, one woman was heard to say to another, "How did you like him?" The other said, "Would to God I knew as little about it as he does!"

I am interested primarily as a priest, and secondarily, as a psychologist in all the problems of human living. Since sex is a very important part of human life, I was very happy when I was asked to share my ideas with you. I labor under a terrific disadvantage because I don't know much about the program that you have here. I understand that it is a good one, not only your own in-service training of teachers, but also the program of teaching that you have already adopted in the school. Perhaps if I listen attentively later, I'll learn more about it. Let me just say a few words which, I hope, will be a springboard for stimulating some discussion later on.

Sex education, as I understand it, is much broader that the transmission of anatomical information. I think the neighborhood drug store is a library for the anatomical right now. The youngsters do have that. Somehow it seems to me that sex education is a part of your broader curriculum which deals with the family unit. It seems to me that anyone who engages in this area is trying to touch the atitudes, the feelings and the values of the young people, and not just transmitting information.

Today I feel that all clergymen are expected to say that the world is going to hell; but I, personally, do not think it is any worse than it ever was. We are just going in different directions. If I am not mistaken, we are living in a period where sex now is, I think, on the brink of being misunderstood and perhaps more misunderstood than before. We know that all talk of sex was repressed for a long time, but I am afraid if I read the signs of the times with a newspaper in one hand and a good book in the other, I see a tremendous pre-occupation not so much with normal sexuality but with abnormal sexuality. This disturbs me a great deal. I think that youngsters know a great deal about deviant behavior. I think it frightens them. I think the problem of pornography is an extremely complex one. The "Playboy" philosophy is very prevalent among high school and college youth. The idea of sexual license, the connection between the use of narcotics and sex, and the erotic stimulation that exists in the mass media are all aspects of this philosophy. All of these to me are symptoms that we are not handling this phase of human living in as healthy a way as we might. One of the difficulties is, as you

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know, that the adolescent goes into puberty now two years earlier than he did twenty-five years ago. Twenty-five years ago, puberty came to a boy about fourteen or fifteen years of age; now, it comes at twelve or thirteen, and to a girl, proportionately earlier. Consequently, their physical capabilities as far as sexual expression is concerned are coming to them earlier and yet our culture is pushing off the time when they can be independent and support a family; therefore, adolescence represents a turbulent and critical period in the life of the individual: a period which some say extends from thirteen to twenty-three years of age. The young people then are saying to us, "How shall we handle these very strong feelings that we have?" This poses a real dilemma, for one of the difficulties is that the adolescent is not really capable of performing the sex act in a fully human way because he's not mature psychologically, even though he is mature enough physiologically. He is not mature enough psychologically to sustain a deep personal relationship: to stand still and be loved. It's much easier to love and run. Through no fault of his own, he is not capable yet of sustaining a deep relationship or of taking the responsibility upon himself for another human being.

One of the difficulties I see as we try to approach this question is the problem of terminology. Would you agree with me that there is much role confusion? I think there is much confusion in the family as to the role of the father, the role of the mother. I see a great deal of role confusion as I study the varieties of clothing. I'm not speaking judgmentally pro and con, but I do see . . . unless my eyes are getting bad . . . from the distance it is harder to tell now who is a boy and who is a girl. I think that this phenomenon of clothes styles says something to us. I think young people are trying to say that we are persons and our personhood is even more important that our sexuality. But this is not the whole problem. What do we mean by sexuality? Here we labor under a real difficulty in terminology it seems to me. We have no word that differentiates the sexes except one which is physiologically anachronistic. In other words, when one talks about sexuality, one immediately gets the picture of a division of the sexes which is physiologically based. The Dutch have a word which is close to our word 'gender'; however, we have no other word than sexuality.

Are there differences between the sexes which are innate and not merely physical? Now, I know one can get a real good argument on this. Most psychologists seem to believe that there are; sociologist believe that almost everything except the physical differences are culturally determined and could be changed. Both as a psychologist and as a religious person my feeling is that there are some psychological qualities which are meant to differentiate the sexes but they are not as important as the personhood underneath. I think this is terribly important. I think that the youngsters are trying to say, "You older people are hooked. You see sex in a different way from the way we do."

I think that to a certain extent they may see it in a little more healthy way than we do. If we listen carefully, what they are saying is that beneath all this is something more important and that is my person-

hood; then, there is that which differentiates me as a man and as a woman and finally there is that which differentiates me as a man or a woman in a genital sense.

Actually, everything we do in the broad sense, in the gender sense, the way one shakes hands, the way one writes a letter, the way one blows his nose, the way one walks, the way one smokes a cigarette, the way that one looks at his nails . . . is sexual. It is terribly hard to be a person without being a man or a woman person. But, if the only way one has to be a man person or a woman person is genitally, then one is forced into making a choice before he is psychologically and sexually mature.

Why is that? Unless one's psychological attitudes develop along gender lines so that he can feel comfortable first with his personhood and then second with his manhood or womanhood, one doesn't reach the point where he can use genital sexuality in the way that God meant it to be used. This is the way I see the problem of the youngster's panicking about his personhood, about his manhood or her womanhood and then using . . . what the world seems to say is the only means . . . the genitality which is most available. Very frequently this brings about sex without love, and both as a priest and as a psychologist . . . and I think you can get a lot of backing on this one . . . sex without love is psychological suicide. Nobody goes through this unscathed. It is absolutely impossible to have sex without a deep personal relationship without hurting yourself and hurting the other person. It is the same as hate and fear.

Let us suppose that I have a terrific prejudice against Blacks and that you are a Black female. Then I look at you with hate. Two people get hurt when I do that . . . you, obviously, but perhaps I am even more so. I corrode as a person when I hate another person, but I corrode as a person when I use another person. Yet young people are saying to me, "How am I going to be sure of my person; how am I going to sure of my manhood and my womanhood if the only way I know how to do it is . . . as you tell me . . . sexually, and that means genitally?" But we adults say one cannot do that. The Church says do not do that. Yet the world says that one must be a person! A man person or a woman person. I am convinced that the more woman one is, the holier one is; the more man one is, the holier one is. This concept ties in very well in the area of psychology of religion.

Another difficulty is this: Man's sexual need is slight as compared with his sexual desire. Sexual desire knows no bounds. It can be felt repeatedly at the slightest stimulation. So we live in a sort of aphrodisiac world in which sexual desires are stimulated all the time and false needs are created. Now, this isn't just in the line of sexuality either. Would you say that to a great extent, economically, our world spins on the idea of creating self needs? If you are interested to make a study, watch your TV some night and mark down all the products that are for sale that were not for sale when you were twenty years of age. Obviously, the need had to be created for the marketing of these products. They

are usually products that make certain you will be accepted into society. Have you ever noticed that? In all advertising there is a great attempt to stimulate in the person the need for something which he must have to be accepted, and unfortunately, if he is not accepted he is not a person.

I feel that we are moving too rapidly away from unhealthy Victorianism which dictated the morality, standards, and attitudes of society at the beginning of this century. We had to move and we moved rapidly; however, we may have moved too far to the other side. I speak now both as a priest and psychologist. Freud saw that society in the Vienna of his day was very artificial. I suppose if I had spoken to a group like this in Vienna in 1900 and used the word 'leg' every woman, who was a respectable woman, would have been expected to faint. Now, obviously, this type of artificiality, this lack of honesty with oneself, this failure to accept the whole person, is unhealthy. Freud, thank God, liberated us to a great extent by bringing out the idea of the id, the ego, and the super ego, and things of that nature which were being unhealthily repressed. Repression is always unhealthy. But, the opposite of repression is not acting out. It is just in this area that Freud is so frequently falsely accused of teaching immorality. Freud was not a religious man, but he was basically a moral man. With all the enemies that he had, one can be sure that we would know some scandal if there had been any in his life. There was none. He was a good husband and a good father.

By repression, Freud meant the refusal through fear . . . usually an unconscious process . . . to listen to the whole person speaking to the self. There are areas of human living which bubble-up. In order to be a person and a man person, without panicking, one must be able to allow these things to come up into consciousness and not repress them. If one represses a thing in nature, it comes back to take its toll. This is an important concept. We too frequently tend to divorce this action from the rest of living. In a society that represses sexuality, in the narrow sense, all strong emotion is repressed; for example, anger. I see now the connection between sex and violence coming out very closely together because as I said, we are spinning away from an overly Victorian Age to a point where our culture, our society, is beginning to admit that there are strong feelings inside of us and some of them are anger, hatred, hostility. If a person cannot tolerate his own hostility and anger, he can't tolerate his sexuality. In fact, I'll go a step further. The only real deep way to control one's hostility and aggression, anger and hate, is to be able to admit to oneself one's need and desire to love. You say, "What do you mean love?" I mean something between the love of God which I believe is the highest thing to which a human being can aspire and the detached sexual act which is neutral. The sexual act can either be coupled with human love or divorced from it. If it's divorced from it, it is bad; if it is coupled with it, it is good.

During the Victorian Age when repression was the order of the day, both anger and sexuality were deeply repressed. The churches, and I say this advisedly, all the churches thought that there was only one kind of love that was worthwhile: spiritual love. Spiritual or volitional love

is the kind that takes place in one's mind and in one's will. It orders the rest of one's life. It is the kind of love that one first thinks of in going up to God and praying. It is slightly different from affectional or emotional love. If one over-emphasizes or divorces spiritual love from affectional or emotional love one seems to condemn all warm human feeling, not only all warm human feelings but even the ability to admit that one is angry and wants to hit out. Most teachers have seen this often in their students: the repressed anger and hostility that comes out in a youngster who is always late, who always drags his feet. These are the students who can really upset the teacher although the teacher cannot really pin-point the problem. In extreme form this acting-out is a character disorder. It is not a good open fight; it is a subtle seathing.

What is the connection between spiritual love and affectional love? Unless we talk about these two we cannot go far in realistically talking about sexual love. When you pray, how do you feel? Well, sometimes you do not feel good. Sometimes there is no resonance in the body. Sometimes the relationship is merely a volitional one. Well, how do you continue, those of you who are married, to take care of your youngsters? There are times when you don't get a lot of resonance there either, believe me; or, if you are a teacher, you have the same reaction to your students. Sometimes you feel that you love them all; sometimes you just come to work. Even the love of God in its fullest sense should be a personal love.

The Church aims now toward this, for the Church has slowly seen what it lost somewhere along the line. This doesn't mean that the Church, and I am speaking of all churches, keeps making errors. The Church is forever building its ascetical theology on an anthropology which is current at the time. Do you know what ascetical theology is? One's spiritual life is always built on whatever psychological or anthropological model is available at the time. Now, the psychological, anthropological model that was available at the end of the last century was one in which man was conceived as almost total reason, almost disembodied reason. Now, on the other hand, the Church is moving from this era of Victorianism, too, and beginning to realize that spiritual or volitional love, although it is the highest, should lead a person to experience warm, loving feelings throughout the whole emotional network. More than that, a person should be able to allow negative feelings to be accepted as a part of himself.

The doctrine of the war between the flesh and the spirit does not mean the same thing today in the Church as it did at one time. This is one attitude that has hung us up. It was a misreading, I think, of Paul's epistles in which he talks about the flesh and the spirit. People immediately thought the spirit was good and this is what was meant by volitional love; the flesh represented affectional and genital love. Now, what does this really mean? The exegetes tell us today that the spirit means an acknowledged dependence upon God and the flesh means total self-reliance. If one reads it that way, one can see that unless one has a dependence upon God, on some Supreme Being, it is pretty

hard to love anyone. Total self-reliance makes it impossible to relate in even an interpersonal way, never mind to relate with the Supreme Being. So, the Church today, the Catholic Church after Vatican II and, I think, the Protestant churches, have seen these things happening; some of them, progressing at different rates of speed, spoke out earlier. One can see in the liturgical things that are happening . . . the amount of emotion that is coming in now. What was once a quiet congregation is now a singing congregation; young people today use guitars and even clap their hands. The Church is still reverent, but it is beginning to say the whole person worships together. The idea now is that the emotions are and can be an ally as well as an enemy to one's perfection.

In summary, I would say that sex education is the teaching of anything of human love. If there is too much repression of anything that is human, it will be impossible to love in a fully, totally, human way. If it is impossible to love in a human way, it is impossible to love God. Every analogy that we have for our love of God is built on personal relationships . . . the mother, the child, the brother, the sister. One of our difficulties, I think, is that just as the Church may have thought too much of love only as a volitional, spiritual thing, I think the world has thought of love too much as a merely genital thing.

Let me be very frank with you. It is terribly difficult to be a single girl or a widow in our culture. Why? Because somehow we have mapped out the areas where love can be expressed between people, and the only models we have are husband and wife and parents and children. What we seem to be saying to those who are not married is that you may not love as a whole person because there is only spiritual love, if you will, or genital love. The whole in-between area hasn't been developed.

I would suppose in sex education . . . I am sure you are doing just this . . . the first aim is to develop healthy emotions of all kinds. Notice, I say of all kinds even the negative ones. There is something even in genital sexuality that has a certain amount of aggression to it, and what is important is that this genital sexuality does not become the main preoccupation, that sex is not used as a weapon as it very frequently is. But the person can best handle himself or herself as a human being if the total amount of feelings are available to the person in consciousness so that he cannot inhibit some and use others. There must be a reverence, a respect, and not a fear of our human feelings. It is precisely this that is leading a large number of people into homosexual relationships . . . the inability to maintain warm, human feelings without feeling that they cannot be genuine unless they are expressed ultimately in a genital union. Emotional love is secondary to spiritual love, but it is essential. At least that is the way the Church looks at it and I, as a priest, most certainly subscribe to this. Affectional love is essential because our feelings determine our rapport with others. Without a special grace it is almost impossible to maintain a relationship over a long period of time on merely a spiritual or volitional basis without the reinforcement of our emotions. Just as it is pretty hard to go to school for twenty-five years unless one likes to study. We don't talk to other

people through the volitional and spiritual love. We meet first at a sensate level, i.e., you turn me off or you do not turn me off not because of what I am saying but because of the way my hair is combed, or because of the good or bad responses you have had with priests in the past. In other words, there are a whole lot of things that go into your relationship with me as a lecturer to a group or into your relationship with me as an individual. There are a number of things that are automatic. It is a mature person who does not deny this, but who says, "Yes, I am too favorably inclined toward him because of past good experiences; now I have to find out what he is saying so that I can criticize him more objectively, or vice versa." It is a very immature person who says he meets a priest without any preconceived prejudices. The emotions, then, are responsible for the depths of our friendships . . . the depths of interpersonal relationships in marriage. It is impossible to fulfill Christ's first and second commandments to love with one's whole heart and with one's whole mind, with one's whole will, unless in our education we learn how to help young people to act positively toward their own emotions.

I want to say something about frustration neuroses. This is a new neurosis. Most of the neuroses that Freud dealt with were repressive neuroses. About fifty per cent of the patients at the Institute for Living in Hartford and at the Menninger Foundation in Topeka, Kansas, are teenagers . . . eighteen years of age or younger . . . and most of them there are diagnosed as character disorders. A character disorder is different from a frustration neurosis but both have this in common: it is impossible for the people to form a real, deep warm human relationship that can be sustained. I would say that this is the real problem today. It is important to learn what it is in the family, in the culture, that is blocking the capacity for real, warm, deep human relationships.

Unselfishness starts with a volitional, spiritual foundation. All human love starts selfishly and certainly our emotional love is basically selfish. The first affectional responses of a child are totally egocentric. What makes an individual's affectional volitional love less selfish? It is continual restraint, the continual finding out what is better for the other person; a continual searching out of how I can wish for my love the better. How can I find out first, what is good for my love? Knowing what is good for my loved one in a volitional and spiritual way then I follow through affectively; otherwise, if my emotional, affectional love takes the lead, there is a grave possibility that I may use my relationship in a selfish way.

The last thing that I want to say is that love of restraint is the only kind of love that makes any sense and yet one cannot talk to junior high school students and senior high school students about restraints of any kind. I do not mean that they do not have a need to control themselves from within, an autonomy, but they do turn us off when we start talking about restraint. The only way I can try to get across what I have been saying to you is to show them that any deep personal relationship

involves a commitment in which a person stands still in his love, which means that he is responsible for the desires of another person which cannot be predicted.

This lack of commitment, I believe, accounts for the reason computer dates are going over so terrifically. College boys, as I read them, would be glad to marry a well-shaped computer. They are not selfish. The young people are not any more selfish now than you and I were when we were young, but they do not want to be surprised. And, if they were able to marry a computer, they could feed into it the information that she would want a mink stole seven years from now so then the husband would know well enough in advance and could save for the mink stole. But, love of restraint means not only not always doing the thing one wants to do. Love of restraint is harder. It means sitting loose because one is committed to another human being who is changing just as rapidly as he is and making demands that he does not foresee. These demands require decisions as to what is the best way to express affectional love. In wanting for the other only what is best for her or for him, this is the way that God told us to love.

EDUCATION FOR SEX AND TOTAL PERSONALITY: THE ROLE OF THE HOME

JOHN V. GILMORE, D.ED.

Most persons will probably agree that the family environment is the most important influence contributing to the child's development. There is less awareness, however, of the role of the home in effecting good sexual adjustment. Appropriate sex behavior involves more than an inborn physiological drive and a sense of social values. It comprises the entire psycho-physical-sexual life of the individual operating within the framework of a structured society which has formulated customs and laws for the expression of sex. Learning the sex customs and regulations and acting on them is but one aspect of sex development. Sex behavior is neither exclusively genital, nor endocrine, nor neurological, nor emotional. It is to a large degree a product of the non-sex aspects of living. Each individual's personality must throughout his life function and maintain itself within the environment of the family and later that of society. Sex and its expression must therefore be viewed as merely one aspect of this ego functioning.

The sex drive of the human organism differs in at least two respects from the other physical drives such as hunger and thirst with which it is sometimes classified. Unlike hunger and thirst drives, sexual activity is not necessary for the existence of life. Even though a happy love life contributes to one's growth, maturity and general personal effectiveness, it has never been established that physical harm has resulted from sex deprivation in terms of pure tissue displacement. Moreover, the role of hormones as a causative influence on the development of certain sexual characteristics has been overestimated. Variations in sex behavior or in secondary sex characteristics such as the body contour have often been related to a theoretical difference in hormones within various individuals. Recent studies, however, indicate that the various kinds of hormones in the endocrine system are partly associated with environmental factors, since the emotional responses which determine the release of hormones are directly related to threat or acceptance in the environment. It has been pointed out that in the vertebrates, especially the higher primates, there is no evidence that sexual behavior is completely controlled by the somatic (including hormonal) factors. For example, in sex deviates, no consistent abnormality in endocrine function has been observed. More recent evidence indicates that the cerebral cortex plays an important part in sexual behavior, especially in the male. Therefore, variations in sexual behavior have essentially a psychological cause and not a hormonal one. (Cofer and Appley, Rosen and Gregory)

The entire soma structure — including the specific functions of hunger, thirst, elimination, air-getting, and sex — is part of the emotional framework through which the ego operates. Sex is only one of the body functions that can be used by the ego as a means of defending itself.

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Since the first concern of the ego is the safety of the organism, the highly charged emotional aspect of sex behavior will be one of the easiest to condition in terms of learning. For this reason, specialists agree that in human sexual behavior one can observe the effects of learning and social conditioning more easily than one can recognize them in any other species.

Sex, controlled and expressed in socially acceptable channels, can enhance the growth of the personality. On the other hand, sex behavior which is not approved by the social group in which the individual finds himself causes considerable guilt and hence withdrawal tendencies. Sex can also be used as a defense. For example, it can be an acting out type of behavior against an environment lacking in nurturance and acceptance. Just as the physiological drives of hunger and thirst can be used defensively, as in cases of obesity and alcoholism, sex can also be utilized for the defense of the organism. Usually anxiety manifests itself in more than one area. Individuals who have lived in sterile or deprived emotional surroundings often experience difficulty in the physical areas of their personality through imbalances in hunger and thirst drives and in physical development, as well as in their sexual adjustment. Since sex is so sensitive to the environment, the ego's attempt to adjust to the varying degrees of acceptance and rejection will reveal itself in the sexual style of life which the individual acquires in this growth process. Therefore, the expression of sex, essentially under the control of the cerebral cortex, is more a function of the ego oprating through the defense mechanisms and laws of learning than a mere biochemical process.

Persons who are developing sex education programs face a two-fold responsibility. First, they must give as much detailed biological information as is possible. In the past it has been falsely assumed that the mere imparting of biological information will insure desired sex behavior. Individual transgressions in sex behavior are caused, however, not so much by lack of information as by an insecure personality structure. The second responsibility, therefore, is to attempt to prevent the insecure and threatened person from using sex as the avenue by which to express his anxiety. The skills of teachers, counselors, and parents must be called upon to help the potential acting out child. Sex education will be effective at its maximum level for a child only when his family environment is and has been an accepting one. When persons within the family constellation can communicate their feelings verbally, their reliance on sex as a scapegoat for tension should be at a minimum. This is the major focus of the present discussion.

In our examination of the parental influence on sex development of the child it will not be necessary to deal in detail with the oral and anal stages of a child's psychic growth as outlined by Freud — which are part of his physiological and ego development. It is rather well established, both theoretically and experimentally, that the young child in the oral stage of life will express feelings of rejection largely through the alimentary canal or the skin. Such behavior is observed in the over-

weight, the underweight, or the allergic child. At the anal stage of development, difficulties in toilet training such as enuresis and constipation are symptomatic of efforts of the child's ego to maintain some kind of emotional homeostasis within a threatening environment.

The child grows and develops physiologically with little reference to sexual development until he is about four or five years old. At this age, called by Freud the phallic period, the child becomes aware of the physiological differences between girls and boys. He begins to examine his own body. This curiosity has been referred to as a form of autoerotic behavior or one of the first indications of masturbation. Moreover, at this age a boy becomes sexually aware that he is different from his mother, a girl perceives herself in a similar relationship to her father, and the so-called Freudian Oedipus Complex or "family romance" develops. In other words, the child's normal interest in identifying with his own sex group pairs him with adult members of the opposite sex within the family. The young boy typically experiences feelings and emotional dependency with respect to his mother, but his father stands in the way of his development in this sociological male role. Similarly, the young girl who would like to be a partner of her father finds that her mother obstructs the development of her sex role opposite the male (in this case her father).

Sex identification begins, then, to unfold as physiological growth takes place. However, this identification process can be complicated by the demands made upon the child at this age. As the child grows, so do the expectations of the environment. If verbal threats and other rejections to the ego have been part of family life since his birth, the child will, during the phallic stage, experience difficulty in the sex role identification process. His situation will be especially traumatic if he is handicapped by psychosomatic condition (i.e. allergies), toilet training problems, and defensive mechanisms of various kinds. The child is also expected during this stage to acquire certain skills. At school he must begin to learn to read and to do arithmetic; he is, furthermore, expected to engage in some form of athletic activity, to develop socially, and to be able to deal skillfully with persons of his own age group. The impact of all these environmental demands, along with the child's growing awareness of male-female physiological differences, can, without proper support and encouragement from the family, be a traumatic experience for him.

Since sex role and sex behavior problems occur with greater frequency in boys and men, our discussion of the impact of the early home environment on future sex development will focus primarily on the boys. (Nevertheless the same rejecting environment, including the role of the non-supportive father, appears to underlie the sex identity and acting out behavior problems in the girl). Problems besetting a boy between four and six involve much more than mere sex identity. The sociological aspects of the appropriate sex role behavior involve stressful learning experiences. A boy's efforts at this age to establish some kind of a sex identification become an expression of "I am what I do." If he can behave like a man, he is active — is actually *doing* something. Since his father

may interfere with the boy's behaving like a man opposite his mother, the son may view him with some hostility. There are, as with any social unit, problems of interpersonal relations in a growing family. The maximum growth which should take place at this important stage can be assured only in an environment which accepts and respects the child. An anxious insecure boy who becomes aware that his body differs from his sister's may become increasingly threatened. His feelings of being different from somebody else may accentuate his insecurity. It will be particularly traumatic if the family's attitude toward the girl is more accepting that it is toward him. Unfortunately, the American culture does not generally view the boy with as much warmth and acceptance as it does the girl. Parents seem to think that life should be made a little more difficult for the boy so that he will somehow become more of a man. They also assume that he will be more of a behavior problem than a girl and that he must, therefore, be treated with a less positive and more disciplinary attitude. They may deal with his boyish tendencies by encouraging activities outside the house where he can play with the members of his own group in "masculine" pursuits. Encouraging the child to leave the house regularly may actually increase his feelings of rejection and may cause some problems regarding his sex identity. Feelings of rejection cause the libido to turn inward. The first fantasy of an insecure and somewhat body-conscious child may be: "If I had a different kind of body perhaps my parents — and especially my mother — would like me." It is easy for a boy to develop fantasies of becoming a member of the opposite sex or to visualize himself acquiring the feminine behavior characteristics of a sister or a mother in an effort to stave off the threat to his ego.

Too much importance has been placed on the "absent father" as the cause of the boy's inability to identify with the male role. A child will normally identify with his appropriate sex role if the person who is a member of that sex group in his family accepts him. The quality of the father's acceptance is much more important than the quantity of time he spends with the boy. It should also be remembered that the father-son relationship can be weakened and even destroyed by an insecure, anxious mother. A boy's normal healthy imitation of his father has been termed developmental identification.

In the event, however, of a family milieu that generates anxiety the boy's ego may find it necessary to identify with the threatening person for its own protection. If the mother, for example, is a non-supporting, non-nurturing type of person and the father is absent for a considerable part of the time, the child may become more identified with the mother in an effort to alleviate his anxiety. This behavior has been called defensive identification. The mother who does not approve of the boy's behavior when he is struggling to be a man gives him no other choice except non-masculine behavior. In such a milieu the boy feels, unconsciously, that if he can acquire some of his mother's characteristics she

will be more accepting of him. In cases of marked rejection he may feel that if he could be incorporated, swallowed, by mother or could even incorporate her himself the threat would be obliterated.

Severely disturbed children may utilize incorporation fantasies but in a less disturbed family the identification process may become one of an imitation of mother's behavior characteristics, her values, and her general means of communication. This identification process may even take the form of identifying with mother's body and attempting to develop her postures and her contours. The defensive identification process may take the form of a "too much alike" behavior pattern. This type of defensive identification involves a rather marked imitation of the mother's characteristics. It becomes a form of symbiotic relationship in which the boy and his mother appear to act as one. It is obvious that this "to much alike" type of behavior produces considerable anxiety in the mother. She perceives the son's behavior problem as caused by his attempting to be like her and feels he should cease to identify with her. Little does she realize that she is creating a situation in which the boy finds it necessary to imitate her.

In many homes the confused sex role behavior that emerges at ages four to six is caused by a passive and inadequate father with whom the boy cannot identify. Occasionally these fathers may be quite successful, aggressive, and active outside of the family. Their devotion to business and profession may leave the wife lonely and she goes to the children, particularly the boy, for more conpanionship. The strain between the father and the mother may be so intense that the mother makes derogatory remarks concerning the father which in turn alienate son from father.

Recent studies of the father's role reveal that the sex role identification of both the boy and the girl in the family group is more dependent upon the father's acceptance and nurturance than upon the mother's. According to others, imitation of the appropriate parent is no longer considered an essential part of sex role identification. They consider as much more important the effect on the family of the manner in which father and mother each express their appropriate sex roles. In any case, the identification with (i.e. imitation of) the parent would appear to be secondary to the general quality of parental acceptance required for the development of appropriate sex role behavior of all family members as perceived not only within the family, but within society generally. The father and mother may be neurotic and confused but if they are nurturing and accepting of their children, the latter will grow into the sociological aspects of their sex role requirements with relative ease (Mussen and Rutherford).

The perception of what is strictly "masculine" and "feminine" in the current sociological framework of behavior has been changing in recent years, particularly as it relates to the male. Physical strength is no longer considered the only characteristic — or even an essential characteristic — of masculinity. The male role in competitive sports has been emphasized in the past. An interest in athletic skill of a competitive

nature can be viewed as evidence of a strong ego. Participation in athletics, however, is essentially a sociological type of competition which symbolizes the role that the boy is expected to play later in business, politics, and the professions. Athletics are often viewed as a basis for leadership training and many leaders in politics and the professions have had some affinity for or involvement in athletics, particularly during their years of education and training. Athletic participation represents the type of role that society expects of a man who is to be a vanguard, a forerunner, a leader in the business and professional world. Such a role requires not mere physical activity but an ability to stand alone, to cope with problems, and to deal with setbacks and defeats. Moreover, in a civilized society the use of mere physical strength is an immature way of dealing with many of the problems confronting the male. For this reason, athletics are essentially an expression of the ego strength of the individual.

Other areas besides athletics are now viewed as vital for the expression of ego strength, coping ability, and sex role identity. A study at the University of California conducted over a twenty-five year period indicated that men who improved their I.Q. score between the ages of twelve and thirty-seven also improved in their verbal ability. The improvement in the I.Q. was associated with higher scores on a masculine-feminine test, indicating that the more masculine traits in the I.Q. group were associated with more verbal ability. Verbal ability is some indication of the ability to deal with the problems involved in business and the professions. Coping ability is associated with articulate skills. The ability to articulate is therefore associated with coping and hence with sex role identification. Previously it has been assumed that verbal ability was peculiar to women and mathematical skill to men. In view of the above study, this assumption is no longer valid (Haan).

In order for the family to function as a unit and for each member to develop into his appropriate sex sole, the father must above all be a responsible leader. The importance of this leadership for the sex identification of the children is validated by a study that was conducted in Michigan. It was found that the sons of men who were entrepreneurs were more secure in their sex role identification then were the sons of the fathers who worked as part of an organization. It was assumed that the father who is an entrepreneur is more of a leader and more independent person than an "organization man," and that he therefore copes with society more effectively. The man working in an organization may be somewhat more dependent and less creative. With other people to take responsibility, he is thus not forced to make decisions. The results imply that the entrepreneur is a better sex role model than the organization man.

The child between four and six years of age brings to the sex identification period his previously acquired defensive or coping mechanisms. The important factor in the success of his sexual identification at this stage is the degree of acceptance and nurturance which he has already experienced during his first years of life. It is therefore essential

that the parents accept every newborn child as a member of the sex group into which he is born. Providing physical care, acceptance, and nurturance for this child should give him a maximum degree of security when he reaches the age of being able to differentiate his reproductive system from that of the opposite sex. It will also enable him to accept without too much anxiety the fact that the father-mother role is a human relationship into which he will normally grow and develop. He will then not be threatened by the father taking his place with his mother and the Oedipus Complex can be reduced to a minimum. The mother in her nurturant and physical caretaking role and the father in the leadership and nurturing role together give the child the security which enables him to develop into his appropriate sex role. An anxiety-free child at this stage normally develops appropriate physical skills. Body awkwardness is a product of confusion over identity and not necessarily a neurological and muscular problem. Athletic skill may be one characteristic of a secure individual since the muscular part of the body coordinates well when the ego feels secure. At this phallic period the boy begins to compare himself with others in skills of jumping, running, chinning himself, and throwing a baseball. The overweight boy will be handicapped in these somewhat normal physical and social competitive situations. Girls who are confused over their identity may have social and other problems with their contemporaries. Usually the girls have fewer problems, for at the ages four to six the average girl has been shown considerably more care, support, and nurturance than the average boy.

In addition to physical skills the boy is expected to acquire academic skills (reading, writing, and arithmetic) in school. Confusion over his identity will result in his inability to function effectively in the academic skills. The learning of the symbols involved in both reading and mathematics requires a minimum of anxiety so that the child can operate independently in this area.

The specialists in the field have sometimes referred to the exploration of the body at this stage as comparable to thumbsucking in the oral stage. The exploration of the body should be looked upon as a somewhat normal stage of development and not necessarily as a masturbation practice. However, when the girl or boy resorts to the constant handling of the genitals either alone or in public, it is symptomatic of a threatening environment causing withdrawal. The exploration of and the holding of the genitals is one way of loving oneself. It signifies a lack of acceptance of the ego and an inability to express feelings through the normal communicative channels. Chronic sex handling should be viewed with some concern, for it is symptomatic of an anxiety-producing family pattern. If the child handles himself in a temporarily threatening situation, parents should not be too alarmed. Should the parents bring undue attention to the handling of the genitals, in either the boy or the girl, the child may use this behavior as a means of getting back at them.

The years between six and twelve which follow the phallic stage of development are often viewed as the latency period, characterized by a

lack of interest in the opposite sex. Boys are encouraged to play outdoors and girls are given more attention and care with indoor activities. Having boys and girls play in separate groups due to the possibility of exploratory sex activities is in part valid, but with careful supervision in a happy environment, boys and girls together will not be inclined to engage in exhibition and other forms of sexual activities. Interest in the opposite sex declines during this period and does not reappear until somewhere between twelve and fifteen.

At the onset of adolescence, the change in hormone development which accompanies normal growth affects the sex glands. At a certain age, differing among individuals, the hypothalamus effects a release of hormones in the endocrine system beginning with the pituitary gland. The hormone from the pituitary releases the hormone from the gonads. Girls mature earlier than boys at an average age of approximately twelve and one-half years, boys between the ages of thirteen and sixteen. The young adolescent has usually not had preparation for the control of the sex drive as it emerges in the maturation process. The boy is particularly threatened and confused over this unfamiliar physiological reaction. The feeling he experiences when a girl looks coyly at him is at the same time exhilarating and threatening. The reaction to sex stimuli is more pronounced in the boy than it is in the girl. Until this time the sex drive has not required any particular control or suppression.

Between the ages of thirteen and fifteen the boy and girl are also beginning to adjust to new sociological roles. Rapid physical growth is taking place and the junior high school is requiring more mature behavior. The child is now asked to make his own decisions and to act independently. His parents have been until this time the authorities and protectors. He is expected to do well in school and to make some long-range plans with regard to his own vocational and educational development. He must be socially adept with his own and opposite sex groups. These new demands in the environment causing increased threats to the ego, combined with the volatile quality of the never-before-controlled sex drive, may set the stage for self-love in the form of masturbation if family communication and nurturance are lacking.

In adolescence the sex drive needs control and direction. If the child has not had information on control of this drive, masturbation, should it occur, is usually followed by guilt reaction. Lack of sex information from the parents at this age is usually interpreted by the adolescent as an indication of not caring. Masturbation becomes then the most common symptom of a sterile, non-nurturing family pattern. It can occur as a solitary activity, but it is nearly always a precursor or a part of such atypical or deviate behavior as pre-marital sex, exhibitionism, and homosexuality. The frequency of masturbation in homosexuality is greater than in any of the other atypical or deviate groups. The masturbatory process is a narcissistic, self-loving type of activity caused by the inability of the libido to leave the body and be expressed onto persons in the environment. When communication with other persons is diminished, the child turns to his self — to his own body. He creates his own

private world and feels no need to be concerned with others. Masturbation is a form of retreat and is a narcissistic, almost a homosexual type of behavior. In private conferences adolescents will reveal that masturbation occurs at times when they are anxious and afraid. A study of adolescent aggression by Bandura and Walters reports that when boys felt rejected, they tended to masturbate more freely than when they felt accepted. The extent to which the boys in this particular study masturbated correlated .36 with hostility toward mothers and .28 with hostility toward fathers. Masturbation also correlates .34 with anxiety over dependency upon mothers, .31 with anxiety about dependency on fathers. More important is the finding that the measures of warmth and acceptance in both father and mother correlated significantly (-.49) with masturbation. This study gives some indication that the extent to which a boy masturbates is related to the lack of love and support. The Bandura and Walters study also suggests "that parents who are anxious about sexual matters may tend to reject children of the same sex as themselves." (p. 137)

As can be seen in the previous discussion of masturbation, an early separation anxiety results in a drive to act out against loss. The rejected or neglected individual feels cut off and depressed. He searches for acceptance via other forms of atypical sex behavior. He may think that one remedy for his feelings of alienation and rejection is some direct physical contact with members of the opposite sex. The narcissistic type of behavior in masturbation, voyeurism, fetishism, and exhibitionism results from a lack of support, or at best, little communication with the members of the opposite sex. The male who preys on the insecure woman has been called a promiscuous person — in reality he is a love addict. His particular form of behavior is that of a person who attempts to fill the void in his life by illicit and premarital sex relations.

Needing acceptance and enduring support, the love addict seeks it in a fleeting kind of relationship with a member of the opposite sex who is in somewhat the same insecure alienated position. Karen Horney suggests that what characterizes the person who takes sex as an outlet for anxiety "is a deep disbelief in any kind of affection." Sexual acting out behavior that results from the emotionally deprived childhood is contrary to established values. The illicit and furtive act compounds the original feelings of depression. Thus, the average individual who is acting out sexually against a lack of support and love usually has guilt associated with his actions. The happy secure child does not feel the need to engage in premarital sex behavior as a means of acting out against parents or to prove his masculinity. The deprived person, and especially the boy, may displace his hostility to his mother or father onto a girl outside the family relationship. He may become quite aggressive and he does not hesitate to take from the girl some physical expression of acceptance of a leaden quality. He may feel he is getting some affection — even though it is pilfered — which has been denied him from a member of the opposite sex. He is simultaneously displacing hurt upon a member of the same sex, namely his mother, who has also not accepted him.

Hostility characterizes a large percentage of pre-marital sex. Although it can be argued that pre-marital sex can occur by mutual consent, the mutual consent theory is not valid when one member takes the initiative — in most cases it is the man. In the Kinsey study, 50 to 60 percent of the men convicted for sexual attacks of women came from broken homes (Gebhard, Gagnon, Pomeroy, Christenson).

The promiscuous girl, on the other hand, is struggling for the same need for identity. As a person who has been deprived of love and affection in the family she may seek it from the insecure male. Her acting out situation results in an unconscious desire to become pregnant in order to get back at her parents for the loss of ego acceptance. In unwed mothers the father is often the object of hostility since he, more often than the mother, rejected her.

Sex behavior reacting to a sterile non-supportive environment can go beyond the concern over one's body and over one's identity. More serious forms of deviant sexual behavior may occur: voyeurism, exhibitionism, fetishism, and homosexuality. A marked fear of the opposite sex indicates a previous ego-threatening experience with one or more members of that group. Fear of women is quite evident in the voyeuristic person who is popularly termed a Peeping Tom. Studies on the voyeuristic person suggest an original fear of mother. These boys and men get a vicarious sex experience by looking. Men secure a sex response by vision; women do not. The voyeuristic person's fear of women leads to social and communication difficulties. He engages in an illicit and furtive type of spying rather than the normal type of conversation and social relations that would be expected of the well-adjusted person.

The voyeuristic person usually has considerable guilt about his anti-social method of securing romantic feeling. He makes a point of seeking out situations in which sex can be viewed surreptitiously. He often has an accomplice who is willing in a seemingly chance situation, to cooperate in his search for persons to view. The voyeuristic person often seeks crowded situations where there can be a non-verbal physical contact with a woman. His basic problem is his inability to be accepted by women, accompanied by his yearning for contact with girls at a distance. In regard to their home background, it has been found that voyeurs tend to be youngest children, fifty percent come from broken homes, and more prefer the mother than the father (Gebhard, Gagnon, Pomeroy, Christenson).

Exhibitionism is another form of atypical sexual behavior symptomatic of a lack of acceptance. Rejection by either the father or the mother results in a driving need for recognition. Being unable to be accepted for their own body, exhibitionists resort to this behavior as one way of proving to their audience that they really are males. (Exhibitionism seldom occurs in females.) The episode of exhibitionism is likely to have been preceded by some form of rejection. It is rather common in an adolescent boy who, while struggling with sexual identification problems, has been rejected by his parents and peers. In the Kinsey study exhibitionists tended to be intermediate children — neither

the youngest nor oldest. More of them preferred the mother (45 percent) to the father (20 percent). About one quarter of those studied had lived entirely with adult females prior to the age of eighteen. Their prevailing preference for mother occurs also in homosexuals (Gebhard, Gagnon, Pomeroy, Christenson).

Another type of atypical sex behavior which keeps the opposite sex at a distance is known as fetishism. As with the two previous forms of atypical sex behavior, the man who uses the accumulation of women's clothing (including shoes and hair) as a means of arousing erotic feelings is a person basically afraid of women, acutely concerned over his sexual identity, and preoccupied with an over-emphasis on sex. Usually these men have had difficulties with parents — especially their fathers. Some men suffering from fetishism are or have been married. Their great need to have a normal romantic acceptance by a woman takes the form of acquiring a substitute for her (a sexual object) rather than communicating directly with her. Poor relations with the father occurred in a high percentage of cases reported in the Kinsey study; these men had had few female companions during their latent and adolescent periods (Gebhard, Gagnon, Pomeroy, Christenson).

One of the best studies on the parental background of homosexuality has been conducted by Bieber and his associates. These investigators studied the mother-son and father-son relationships of 106 diagnosed homosexuals and 100 men diagnosed as non-homosexual. Of all the variables associated with the homosexual's family background, the most statistically significant was the Close-Binding-Intimate mother. The findings indicated that the C.B.I. mother openly preferred the homosexual son to his father. She not only tended to isolate the son from his father but encouraged father-son competitiveness by pitting one against the other. She would isolate the boy from his siblings and his peers and instead encouraged adult relationships. Quite often she was involved in a romance with her son as a substitute or compensation for disturbances in her own marital relationship. The son was often included in inappropriate situations such as sleeping arrangements. C.B.I. mothers also preempted decision making and then "took over." The relationship was characterized by the son's timidity rather than by an interacting self-assertiveness. There was a tendency for these mothers to bind the child to them. The father — who was often absent — was not encouraged to enter into the father-son relationship and the son became in effect a kind of maternal possession (Bieber, et al).

The father-son relationship in the homosexual group was quite unrewarding. Of the 106 fathers of the homosexual group, 79 were classified as "detached" fathers: of these 18 were distant and indifferent to their sons, 34 were hostile, and the remaining 14 were ambivalent. Very few of the fathers of the homosexuals took a firm stand in protecting the son against the detrimental influence of the mother (Bieber, et al). The father's withdrawal from a responsible role in the family has in recent studies been found to be characteristic of other behavior problems as well as sexual. The somewhat archaic idea that the mother and the

father should agree and support each other on any and all decisions which one of them has made unilaterally may have a devastating effect on the child's development. The failure of at least one parent to support a child in an ego-threatening situation causes the latter to mistrust the omnipotence of his parents. The child needs someone to believe in him, someone in whom he can have confidence and faith. A detached and withdrawing father can cause the child to submit to the mother or to seek support elsewhere, even in fantasy. In most cases it is the father's responsibility to make decisions as to the values of the home, and he should prevent destruction of the child's ego by the C.B.I. mother. In some homes, of course, the reverse situation occurs — the physically and psychologically punitive father needs to be thwarted in his punishing techniques by the mother. In the typical case of the homosexual, however, it would appear that the father, even though present, is detached hostile and rejecting (Bieber, et al).

Dr. Bieber's study on the pre-homosexual characteristics of his experimental group is important when we are discussing the influence of the family on sex role adjustment. The researchers found in studying the early home life of these men that less than 20 percent of them had participated in the usual boys' games. About one-half were loners and about another one-third played predominantly with girls. There was also an excessive fear of physical injury which, in both groups, appeared to be associated with psychopathic parents. Parents concerned about their own health were often excessively restrictive of the boy's activities. This concern in turn interfered with the latter's self-assertiveness and heterosexual development. The fathers of the homosexuals were nearly always hostile and rejecting (Bieber, et al).

In another article, Dr. Bieber discusses the home background of the pre-homosexual girl. (Overt homosexuality in women occurs infrequently.) The mother's relationship with these girls is likely to be one of rejection and authoritarianism. She criticizes them for clumsiness. These girls are not permitted to work in the kitchen, and they are rarely taught other feminine skills such as cooking and sewing. The mothers of these girls as a rule do not dress them becomingly, although they do not necessarily make them wear severe clothes. The father's role is seldom one of acceptance. He may reject the daughter completely or become overly involved with her. Fathers commonly side with their wives against the daughters when a dispute arises (as they do with the sons), and they usually fail to protect the daughter when the mother is treating her unfairly and destructively (Bieber).

In regard to homosexuality and other forms of deviant sex behavior the importance of the father has heretofore been underestimated. Although the studies by Bieber and other researchers indicate that the mother bears most of the responsibility for causing male homosexuality, to blame her alone is an oversimplification (Wyden and Wyden). The mother's Close-Binding-Intimate behavior may be related to the father's irresponsibility and passivity. If the mother has a negative influence on the son it is the father's duty to prevent further injustice and consequent

harm to the son's development. Homosexuality does not develop when fathers have had a warm relationship with their sons. Sons must be able to admire and identify with the father or a father substitute in order to become well-adjusted heterosexual males. It is not the amount of the father's time spent with his son, but the loving quality received and remembered by the son and reinforced by the mother that is the vital factor in his sex role identification (Wyden and Wyden).

In view of the theoretical and research data presented above, it is evident that merely imparting biological information cannot solve the problems of sexuality in the personality. Biological information is, of course, imperative: adolescent boys complain that sex information given by parents is generally "too little and too late" (Bandura and Walters). The insecure acting out individual often amazes the psychologist by the pat answers that he is able to give to questions on proper social behavior. Nonetheless, his need to act out against a lack of support in his milieu prevents him from internalizing the values that should make for more effective living. Adequate sex instruction should be consistently given by parents. Nevertheless, the important factor in sex behavior is the quality of the parent-child relationship. Courses in child psychology, family dynamics, factors in healthy personality, and, of course, information on sex education techniques should enable the parents to do a more competent job with their children. The findings reviewed here indicate that, for a better sex role identification in both boys and girls, the father must assume more responsibility for family leadership. In this role he must be an accepting and nurturing person. Father and mother should above all collaborate in their respective sex roles in an empathic, rewarding relationship to each other and to their children. Such a relationship is absolutely essential for effective family living.

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BIOLOGICAL FOUNDATIONS OF HUMAN REPRODUCTION

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When we talk about the normal menstral cycle, we find the mean age for onset of menstruation is fourteen years, but anywhere from about ten or eleven through seventeen years of age is considered normal. Moreover one thinks of a period as lasting twenty eight days, but this is not necessarily true. Most gynecologist will say, I believe, that anything between three weeks, twenty-one days to five weeks, thirty-five days is perfectly normal. This, then, throws confusion into the young person trying to figure out at what point in the period she is ovulating. It is not true in the majority of healthy, normal women that the period is always precisely the same. Many normal women apparently vary one, two, or three days within a few months; therefore, it is not simple to determine by such methods as the rhythm method when there is a safe period for intercourse. The bleeding period, normally five days in the twenty-eight-day cycle, can vary and be perfectly normal anywhere from one or two days to up to ten days. We see in all areas of biology there is great variation within the normal limits. Perhaps the most exact part of the whole cycle is the time between ovulation and the beginning of menstruation in everybody. Regardless of the length of total period there are fourteen days between ovulation and the beginning of menstruation.

The two main hormones produced by the female ovary are estrogen and progesterone. At the time of ovulation there is a change in emphasis from estrogen to progesterone, which is then secreted in the body for from about the fourteenth day to the twenty-second day. If the ovum has not been fertilized, the progesterone secretion ceases causing the cycle to conclude itself with menstruation.

The mean age of menopause is about fifty years although here, too, there is great variation. This is of interest because there has been considerable discussion as to whether women in their forties should continue to use birth control methods if they do not want to have children just before menopause.

Another important area for consideration is the field of fertility in man and woman which, of course, leads into the concepts of contraception. As I am sure all of you are aware, there are now large clinics which specialize in fertility problems. This is a very acceptable and quite robust medical specialty, especially in a town like Boston. A sperm normally lives and is capable of fertilizing an egg for about forty-eight hours. However, because the ovulation period cannot be predicted exactly unless one carries out temperature measurements, authorities consider the fertility ovulatory period to last from about day ten or eleven through day sixteen or seventeen. Obviously then, if one is using the rhythm method for contraception, this leaves only the first eight or so days of a period and the last eight or so days of a period in which one is relatively safe.

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People who do work in the fertility field have different recommendation concerning frequency of intercourse for a couple trying to have a baby. This averages out to a recommendation of intercourse two or three times during the six or eight-day period when ovulation may be possible. The point is that the sperm does live for two days. One is not usually sure of the day of ovulation, but intercourse any more frequent than every two days may not allow the spermatozoa at the time of ejaculation to be as healthy as possible for an individual man.

Perhaps the best and most accepted way of determining exactly when ovulation occurs is the temperature method. With this method, either oral or rectal temperatures are taken precisely at the same time every day over a period of several months. In this way one gets a pattern of temperature change so that the time for intercourse can be preplanned. To rely on noticing a specific change on a particular day and then plan to have intercourse that night puts too much emphasis on the specific day, for it may be a day when the wife or the husband had a bad time at home or at the office. Emotionally then, this is not a good idea. It is better to establish a pattern and then work oneself into planning intercourse according to the pattern.

There are many more extensive and complicated examinations that can be performed to aid conception. One of the earlier ones was to use air or carbon dioxide gas to see if the fallopian tubes were indeed patent. Presently one of the most common preocedures is to do a culdoscopy, i.e., to give local anesthesia to a woman in the examining stirrups position, to make a slight incision, and to look with a culdoscope. This instrument has a light and a lens and enables the examiner to view the position of the ovaries and tubes. This is now done without very much discomfort and produces a lot of information for the gynecologist specializing in fertility problems.

When one talks about fertility, however, the probability is that the man is just as responsible as the woman for infertility. Perhaps in forty per cent of the cases, it is the man who is infertile, rather than the woman. This, of course, comes as a shock to some men, but it is the reason that most clinics, even the gynecologist working in a fertility area, also tries to do a physical examination and, perhaps, semen analysis on the man.

In men there are two large categories of problems with sub-fertility. One is difficulty in placing the sperm in the right area. This can be caused by impotency or premature ejaculations. A man may also have anatomical abnormalities present from birth or because of a disease have difficulty in obtaining or maintaining an erection long enough to deposit the sperm up near the cervix. If the sperm are introduced just inside the vagina near the labia, then the sperm may not have the same success as when they are deposited right at the cervix of the uterus. The other large area of sub-fertility problems in men involve the actual sperm themselves. There may be too few or they may not be active enough, they may be improperly constructed, not viable, move too slowly, or be sick. These situations are not uncommon. Diagnosis can be made by

having the male bring in a specimen of sperm. Gynecologists point out that the sperm must be examined within two to six hours after the time of collection. They have to be collected properly in a glass jar, etc.

There is one satisfactory way of solving many of these problems although in many societies and in some religions it is taboo; this is the method of artificial insemination from hisband to wife. This method is quite acceptable in some societies and works quite well for a man who is relatively infertile. Artificial insemination has to be carried out within an hour or so after the man masturbates into the proper container. This represents sophisticated medical care and is available in a large medical center and in some peripheral medical centers and fertility clinics.

Besides the biological problems we have touched upon already, however, infertility in many instances may be the result of a psychological problem between husband and wife. Many marriage counselling services are available for help in these cases. Actually, doctors find the most common difficulty is lack of knowledge. Old wives' tales are still very existent and many otherwise very sophisticated individuals are not very well educated in terms of sex education. This is one of the reasons, I think, that many programs which attempt to educate students have, indeed, accomplished as much by educating their parents.

Contraception is another aspect of the reproduction processes that need exploration and knowledge. Male contraceptive techniques are few and quite limited in number. There are two actually: the condom and coitus interruptus. Of these, the first method has a relatively high failure rate for obvious reasons: there can be leakage around the condom. The other technique depends upon one person keeping his thoughts upon interruption at a time when it is not easy to do so. Therefore, most of the contraception methods now deal with the female, so much so that in England, where much work in contraception has been done since the early twenties, the advice services were called Mothers' Clinics because it was the indigent mother of six or eight who turned to the social workers of the twenties in post-war Britain. Diaphragms are old, well-established, and fairly safe methods especially when they are used with the additional method of adding jellies and other contraceptive medicants to the vagina after intercourse.

In this country today the most interesting and raapidly developing method of contraception is the intra-uterine device, known in medical circles as the IUD. This has actually been in use here for about six or seven years. It's even newer than the pill in terms of widespread practice. It was first used in Germany in the twenties. At that time doctors placed a little silver or gold device in the uterus which seemed to prevent conception. But the devices fell into disrepute in the rest of the Western world in a matter of two or three years, for it was thought they caused infecions and involved a sort of hocus-pocus. But in the late fifties, in several areas of the world, doctors began to use IUD's made out of completely non-reactive plastics that could be inserted in the uterus, which seemed to produce no reactions at all; thousands of women in Korea, Taiwan, and Japan have had the intra-uterine device inserted.

The success rate for this technique is actually as good as the pill. In other words, it's far better than anything we've ever had before, except for the pill, and it's probably as good as the pill. Many authorities in population explosion work believe the IUD may be the ultimate answer to the over-population problem because it is a much easier method of contraception than the pill.

Why is it easier? Because the woman on one occasion merely has to visit a clinic set up in a school or wherever. After proper examination to make certain that there is no tuberculosis or other severe disease of the organs, the technician or the physician can insert the device through the cervix into the uterus. Women who have had babies do not even require anesthesia for insertion; it's not as painful as a pelvic examination at the gynecologist's. Apparently even some young people do not need to have anesthesia though they have not had a child. The strange thing is that this approach seems to be very acceptable to most societies in which it has been tried. The reason the technique is so effective is that it doesn't rely on individual patient control at all. On the other hand, the pill has its incidence of failure, for if a woman forgets to take a pill on day fourteen, the chances of her becoming pregnant are particularly good. One cannot forget the intra-uterine device; it is there.

Another interesting point about the intra-uterine device is that no one knows just why it is so effective. Some propose that there is a mild irritation that interferes with the mucous lining of the cervix or the uterus; others say that this is not true. As a matter of fact, the authorities are unable to answer whether this is contraception or abortion because it is very possible that the egg is fertilized and that it seats itself in the uterine wall and begins to grow, and then because of this piece of plastic lying in the uterus, there is an unrecognized abortion. Any loss of the fertilized egg in the first week or two can be unrecognized since there is not enough tissue to be seen. Subsequent discharge would be considered merely an ordinary or slightly abnormal menstrual period.

Americans seem to be most interested in the oral contraceptives. There are many products on the market now, and I for one can't say whether one is better than another. Use of an oral contraceptive does, in many instances if not most instances, require the attendance of a physician who has had some experience in the field. All pills are combinations of estrogen and progesterone, proportions and types of which vary from one pill to the other. Since each of these steroid hormones has its own effect, the successful use requires the proper pill be taken . . . the one with high estrogens for one lady and the one with high progesterones for the other. This requires technical manipulation on the part of the gynecologist.

Contra-indications that have been proposed by the Food and Drug Administration and conscientious physicians and surgeons have been few; the answers are not entirely resolved. Avoidance of giving the pill to young girls who have not closed their bone surfaces yet is, I think, very valid. I would say that bone closure probably occurs in most young girls by the age of sixteen or seventeen.

The other area that appears to be developing relative to, if not in absolute contradiction to, is in respect to the woman who has had some experience with breast cancer. There is at least the possibility that the pill may be not recommended to her nor to the woman whose mother or sisters had breast cancer. However, this theory requires much more statistical evaluation before a definitive answer is forthcoming.

The other complication which is under consideration and, I believe, is not as bothersome as was feared is that of thrombosis of the veins of the legs which can lead to further complications such as an embolus to the chest. Certainly the number of people taking the pill is very, very high and the number of these complications is extremely low; therefore, one has to view the problem objectively.

What is the mode of action of the pill? It is strongly suggested that the pill acts primarily by supressing the pituitary gland in its role of stimulating ovulation. There is much evidence in man that the pill acts in three different places: first, the pituitary gland; second, directly on the ovary itself; third, it may even make the cervix unsuited for sperm permitting them to die before they actually reach the uterus.

There are a number of problems one can talk about in reference to the pill. For example, the duration of treatment, for it's only been in use for ten or eleven years; therefore, the ultimate answer is not known. I notice that the Food and Drug Administration said that it could be used initially for one year. Then it stated two years, three, and four. Perhaps there will be some women in the next decade who will spend most of their productive lives on the pill. The answers are not all in yet.

We should all realize that the effectiveness, or lack of effectiveness of oral contraception is due most often, not always, to forgetting to take the tablet. There are different programs for tablet taking. Some women take a pill for twenty days and stop for five; some authorities recommend twenty-one days and stopping for seven. This, at least, has the advantage of a woman's doing the same thing on a given day of the week, every four weeks; for example, one stops and starts on a Thursday or a Sunday, all of which makes the method easier to remember.

SOME ADOLESCENT PROBLEMS AS VIEWED FROM THE DOCTOR-PATIENT RELATIONSHIP

ROBERT P. MASLAND, JR., M.D.

I was asked to talk with you about what young people have to say, and what they are coming to see us about in the field of sex. I am reminded of an article I saw in a high school newspaper recently written by an enthusiastic editor who thought parents ought to know that young people are getting a bit bored hearing about sin in the world. The article was to the effect that schools had furnished students with a great deal of information about sex and all the dangers inherent in sexual activity. The schools had sponsored programs on smoking which implied that one would certainly be a "goner" at age sixty-five if one smoked, but fortunately, this doesn't mean much to most teenagers — polls taken in high schools show that most youngsters think cigarette smoking isn't so bad. The article went on to say there had been some lectures about marijuana and the dreadful things that could happen to one, not only from marijuana but from the other more exotic drugs. Finally, there were lectures . . . this was far down on the list and probably an indication of our times . . . on the subject of alcohol. The lectures left students the feeling that alcohol was not the problem that drugs are; however, there were some dangers in the indiscriminate use of alcohol. The column concluded with the idea that schools will soon run out of vices to talk about and won't have anything else they can really lecture to teenagers about with regard to the sins of youth.

Today I think this is true about sex education. I, as a physician working with young people, view sex as just one of the things which interests and concerns me in my practice. I believe that the whole purpose of adolescent medicine is to have a practice open for all adolescents regardless of the problem. As a result, in a busy day at the clinic, I might see a youngster with diabetes, one who is failing at school, one with a problem in the area of sex. In other words, as a physician concerned with adolescents, I see a variety of problems. However, after spending a number of years with teenagers, I have developed an awareness of their particular needs in the field of sex education.

It has become apparent to me that the adolescent doesn't need a series of illustrated lectures with all sorts of medical jargon about the sexual development of the human being. I do that which I hope you would do with your youngsters if you were asked a question in the field of sex. I answer their questions in a direct fashion if I know the answer. If one doesn't know the answer, it is necessary to find someone who does. This is what I do. For example, in the age range 11-14 years, most girls begin their menstrual periods. It is a visible and definite thing which shows this young lady that she now is entering into adult life. Many questions are asked by young girls who have menstrual problems concerning irregularity, cramps, too much flow, or too little flow. In this

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situation a girl needs a firm opinion as to whether or not her periods are normal. The word that adolescents like to hear more than anything else is "normal." If one is a physician and is asked a question that has to do with the menstrual cycle, I think the whole subject has to be worked out with the youngster. If she is normal, she is told so and if not, the doctor does something about it. Those who have strange and inadequate information about the menstrual cycle often develop neurotic feelings about what it means to be a woman.

Family doctors are asked to give manuals or booklets to the girls to read. Parents do try to impart some information to their children, but frequently their own backgrounds are limited.

We need doctors who answer questions, giving a good explanation backed up, if necessary, by a physical examination. We can determine a great deal about menstrual difficulties without always doing a vaginal examintion. This information is helpful to the young girl, and certainly helpful to her mother, who perhaps believes that a doctor may do a vaginal examination and for this reason she may deny her youngster the opportunity to see a physician about menstrual problems.

Secondary sex characteristics are of great concern to most young girls. The "shape" of things to come is very important to young girls and, I think they feel assured after a good medical evaluation of the situation. It can be helpful to girls if they have problems about proper development of secondary sexual characteristics. I don't think a young girl would walk into my office and say, "Doctor, I am concerned because I am still flat-chested!" But if, during the course of the examination, regardless of what she comes for, the doctor makes some comment to her about the fact that she is developing in a perfectly normal fashion, the girl will have her fears allayed. Sometimes, during the course of a physical examination, a young girl might say something like this, "Doctor, I seem to be a little bit bigger on one side than on the other." This type of breast asymmetry is perfectly normal as long as it falls within a reasonable range. Reassurance can be most helpful to a young girls as she is beginning her adolescence.

With the 15 to 17 year-old age group of girls, when heterosexual activity becomes much more active, I find again, regardless of the initial complaint, they are more than willing to talk about personal relationships; particularly those with boys. They are anxious to get sound, medical information about sex. Once again, I would say that we do not give illustrated slide talks on sex. We just answer questions and give them the pertinent information. The subject of birth control may interest some adolescent girls. They may know girls in high school, and they know about colleges where girls can find these pills without having to go through a doctor. They want to know what the pill does and whether it has any long-term effect on their ability to have children later on. They ask these questions without embarrassment, and we answer them without embarrassment. I think this is a healthy atmosphere for the girls because the information is given in a dignified manner.

Girls may ask questions about abortion. We are careful to indicate that we hope this is something they won't have to face, and we tell them that there are great dangers in illegal abortions. We also tell them that if they ever do feel that they have a problem or that they think themselves pregnant, that we hope they would talk it over with a bonafide physician before rushing off to an abortion mill. This kind of information is honest and forthright, and it may prevent some youngster from getting into serious medical and psychological trouble later on.

We are asked whether or not Student Health Services should dispense birth control pills; whether we should have contraceptive information made available even to high school boys and girls. My professional and personal opinions would be that this is not a good thing to do on a wholesale level. I think one must *individualize*. The physician should be given an opportunity to talk with each individual about whether or not he feels that he or she would like to use contraceptive methods. I do not think that schools, public or private, or colleges, should engage in full-scale birth control ventures. I think it may intimidate and encourage many of our youngsters to do many of the things they would not ordinarily do. Youngsters do like to have some built-in safeguards; they do like to have the adult world say "no" occasionally. Certainly, just giving information to every boy and girl is not going to solve all problems. It may lower the rate of illegitimate pregnancies, but it won't solve the whole problem.

As girls get to college age, if we have had the opportunity to follow them for medical or psychological problems during the early adolescent years, it is not unusual to have these girls come back and see us again during college vacation periods or, before they get married, to ask again for the kind of advice that we gave them when they were younger. My experience has been that it has been helpful to them. I think these youngsters have stayed out of serious trouble in college because they felt that they had someone with whom they could talk professionally.

Boys in their psycho-sexual development are not apt to have this same dramatic interest in puberty. As we all know, the boy is apt to be a little bit behind the girl in his maturation index. In the seventh grade, all you have to do is look around and see all the sophisticated looking girls and all the choir-boy little fellows who aren't able to keep up with these girls . . . at least in the physical sense. Seventh grade girls are really making eyes at ninth grade boys and ninth grade boys are glad to have some girls making eyes at them after their two lean years when the other girls weren't paying attention to them. We have these little fellows, a few of them may have stayed back or maybe they got a little extra shot of androgen when they were in the sixth grade. Their voices changed and they got more muscles and they looked bigger, but they were still immature fellows in spite of their physical changes. Boys are deprived of anything as dramatic as the on-set of the menstrual cycle to remind them of the fact that they are now entering puberty. They might talk big, act big, look big, and smoke cigarettes, but they are not really maturing until they have secondary sex changes which

are voice change, increase in body and facial hair, and increase in stature. Boys may grow as much as six inches in a year during their adolescent growth spurt.

We do have boys who are concerned because they feel that they are not maturing properly. Again, as with the girls who have menstrual problems, it is very important to do a careful physical examination and to be able to reassure this boy that he is normal but that he really hasn't got his secondary growth and development yet. We don't call him a little boy. He doesn't want to hear that. Interestingly enough, we have mothers who complain— fathers rarely do — that their boy seems to be maturing too quickly and precociously. Occasionally this problem might arise because someone in the community has become concerned because a particular boy seems to be so mature, and the ugly phrase that perhaps this boy is becoming too sexually advanced for his years is stated. We have boys referred to us because of masturbation problems. Boys are referred to us because they think . . . someone thinks . . . there might have been some kind of homosexual play. This is the type of problem that comes to our attention usually with a boy between the ages of 12-15.

It's quite important, I think, to be a little more than just a family doctor when doing a physical examination. I think evaluations of a boy's sexual development require that the physician have an opportunity to talk with a boy more than once. In addition, we spend time talking with the mother and father with regard to how they feel about this boy's sexuality and how they feel about his growing up. If, after three visits and a good awareness of the parents as to just what's going on, we do feel that a boy needs a good sound psychological examination, we certainly encourage the parents to have the boy tested. We don't rush every boy to a psychiatrist at ages 13 or 14 unless there has been some suggestion of excessive masturbation or perhaps some homosexual activity which can't be very well verified. We only go on the fact that something has caused great concern and has often struck terror in the hearts of the parents. We prefer to slow down the whole process and come to a reasonable conclusion as to just what sort of help is needed.

The same thing is true with any kind of sexual aberration during adolescence. It is easy to say, as a well-meaning teacher or physician, "I think that little boy is effeminate. I think he's got problems. I think he should have help. I think he should see a psychiatrist." In effect, he may not be having any unusual homosexual feelings. He is actually going through this phase of trying to establish an identity as a male. He does have doubts about it. He doesn't know which way he is going to go, but again, we can't force this type of diagnnosis on him by pointing an accusing finger at him because he wants to be an artist or interior decorator, etc. It is unfair. All of us working with the adolescent age group, particularly the doctors in our clinic, do make every effort to help such a boy achieve a normal masculine pattern, but at no time

do we feel that we must rush him off for a complete sexual analysis when he is 13 or 14 just because he may have had some minor slip or difficulty in this area.

When we go into the 15-17 year-old group, boys have the same problems that girls have because either they are the ones being sought after or they are the seekers. They are trying to establish themselves as heterosexual beings. Boys are not as articulate as girls. They are much more embarrassed to talk about their own sexuality. They are afraid that if they talk too much about it that maybe we might find something wrong with them or some reason why they may be an inadequate male. They are defensive about it. They would rather talk about cars, motorcycles, sports, etc. Sex is a subject boys tend to avoid when talking to adults unless they are extremely bright and extremely verbal. I can't give you any first-hand information about the normal range of boys in mid-adolescence who are verbally concerned about sex. Girls are concerned because they know they can get pregnant, and they want to know as much as they can about this whole area of reproduction.

When boys go to college and come back to see us during holidays, they will then talk about sex. A reason for this is that they find that if they do get involved with girls on a sexual level, and many of them do, they think about marriage, family. "What in the world am I going to do? I'm not ready for marriage." How much help the other doctors and I are to them, I don't know, but it's nice to know that eventually the male will get around to talking about sex, his responsibilities and other aspects of adult life. It's a little late in coming and it isn't as open as it is with the girls, but they do make an attempt to establish some kind of talking relationship about what it really means to be a man.

When the Adolescent Unit was first started in 1951, I don't think we anticipated that we would have doctors who would, out of necessity, have to know this much about sex and sex instruction. For the first ten years, most of our work was with medical and psychological problems but we didn't do very much in the whole area of sex education. Then Dr. Mary Calderone came on the scene; she intrigued and interested not only Dr. Gallagher and me but also other physicians throughout the country. She pointed out that we had been neglecting this area. We felt that we ought to do more about this and that's why I'm here today and why I have been going to other places and talking about the need for sex education.

I am very interested in having courses in sex education in the schools. I think we ought to have these types of problems discussed at meetings like this and brought to the attention of parents. Parents would be quite concerned if we suddenly introduced sex education in the schools because they would be afraid that we would teach the wrong things and that we might stress certain sexual aspects which would be exciting and provocative to the young people. Our answer to this is that for the last five or six years we have become more involved in sex education, and we have learned students today are more sophisticated, mature, and interested enough to be given the facts and the truth. I think

that with this type of information young people are much better off in the world today. We adults are not always going to be able to rush to their rescue. We like to think that we can. However, it is far better that even before junior high school young students begin to have some understanding of the biological differences between the male and female. During the seventh, eighth, and ninth grades they need to have much more factual knowledge about the whole aspect of reproduction including male and female human beings and not just about the lower forms of life. Then during the tenth, eleventh and twelfth grades, a series of worthwhile meetings about responsibility: what it really means to have this sexual ability, how to use it wisely and well, and to understand what it really means to be a man or a woman.

If we do this in our school systems and couple it with support at home, I think we can hope for and expect a far better informed society twenty or thirty years from now than we have at the present time.

NARCOTICS: DRUG ADDICTION

DAVID MYERSON, M.D.

I think the first thing I shall do is defensively say that as clinical director of the Drug Addiction Unit, Boston State Hospital, I have had no personal experience with drugs other than taking aspirin and codeine occasionally for pain. Once when I was sixteen years old, I caught a dreadful case of poison ivy and my father, who was a doctor, gave me a shot of morphine. I remember sleeping for twenty-four hours. That's the only trip I've ever taken!

I come back to my experience as a clinician. For the past three years I have devoted the major part of my professional activities toward directing a program for the rehabilitation of those people who are addicted to or who abuse drugs. The center of our operation has been in a rather small ward in a very large hospital, the Boston State Hospital. We function more or less independently; we are State sponsored, and we have a Board consisting of the Commissioners of Correction, Public Health, Mental Health, and Youth Service. Having so many people on a board is wonderful because they are all so busy they can never get together. That leaves me to do pretty much what I please! I think it's the only way I could operate. At the moment, the ward has seventeen beds. There are facilities for out-patients, in-patients, day care and half-way house procedures, i.e., in a small way the clinic covers all major psychiatric approaches that are used in the most progressive hospitals at this particular time.

The size of the clinic warrants a comment. I think it was really Dr. Harry Sullivan, who was the Commissioner of Mental Health at the time of the passage of the law, who established the idea. It was his contention that the clinic should be small; it was not to make any attempt whatsoever to service the State; however, it was the only unit in the State until very recently. We're not supposed to service the State in the sense of covering the numbers of people who are involved with drugs, or the courts, or the prisons, or the hospitals, or the schools, or the community at large.

What we are supposed to do is to work out different methods to see how effective various approaches can be with this multi-determined and complicated problem. It is indeed complicated. The whole concept is so new and so vague and the literature itself so hazy about what is going on that there really are no guidelines. Strickly speaking, if one is to test various methods, one sets up a specific goal, a specific modality of treatment, and then compares it to a group that doesn't receive this kind of treatment. The trouble is that there is no group we can use for comparison. We have simply started in a rather virginal way. Three years have gone by. We have seen about six hundred persons, but we have not attempted to treat them all. We have attempted to treat about two

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hundred and twenty-five in one way or another through the in-patient service, and what I am trying to do is to assess what we have done over the past three years.

What I want to do now is to share the phase of thinking that I am in at this time. It is not complete; it is not terribly sophisticated, scientifically that is, but I think I can present some feeling for the problem, some feeling for the experiences we have had these past three years and, from this, perhaps one can get some idea of the nature of the problems that we are all up against, every one of us.

I can share some secrets. I mentioned, for example, that about two hundred patients have gone through the program. I have broken down these figures in terms of degrees of improvement and I have found, not unpleasantly, that about twenty-three per cent of this particular group did extremely well, not in the sense that they were always angels or always acting drug-free, but for the most part, they were functioning as citizens. They were supporting their families, if they had any; they were being reasonably loyal to their parents, if their fighting was within the house and not on the streets. Twenty-three per cent were not in serious anti-social difficulties that so many drug addicts can be in.

Approximately another eighteen per cent improved in the sense that they got off drugs, out of the drug-way of life. But, they have become more or less dependent and give us the impression that if we were to disassociate ourselves from them, they would collapse immediately into the previous mode of existence.

Then there was another group of patients, perhaps another twenty-two or twenty-three percent who came to us only in times of crises, i.e., with medical problems, surgical problems, obstetrical problems. They are a chaotic group with whom we functioned as a social service agency . . . a clearing station as it were. We directed them into the proper channels that opened the doors of hospitals, welfare agencies, better facilities for their children, etc. In that way we were public health oriented and it was indeed a public health problem even though, in a clinical sense, they did not really improve in their drug-way of life and in drug taking. Nevertheless, we accepted this as a fact and were able to help them in their relationships to the community.

There was another group of thirty-eight per cent or so with whom we couldn't really effect any improvement one way or another. We had very little to do with them, or they had very little to do with us. There are a multitude of reasons for this, but I shall not concern myself with this at present.

I mentioned the results first because they are of a significance which I wish to emphasize; that is, there is a cross-section of patients who are addicted to drugs who respond to a particular program in different ways and are able to either restore themselves to a reasonable mode of existence or to develop themselves in such a way that they can live reasonably. This group contrasts with other patients who are just so cut apart, so broken up, for one reason or another, that it is just a question of keeping them alive and keeping the families alive. Therefore, one

really can say that there is no such thing as a drug addict. Such a term implies a stereotype. One can say there are people who are addicted to drugs or who abuse drugs and, like any group of people, individuals within the group vary from the very clever, confident, and intelligent to the out-and-out stupid, ignorant, and foolish. There are people whom you like and people whom you don't like; there are people who are high born; there are people who are low born. Indeed, the kinds of patients we have seen at the clinic have been a cross-section of the population.

Let me tell you a little bit about the background of the patients and what we have seen in terms of their ethnic backgrounds. When we first opened the clinic, our ward was quite Black. None of these cats came from a suburban area. They were the ghetto population with their own patois, their own lingo, and their own mode of existence. As doctors, we had to adapt to this group to be effective with treatment. The hospital itself is located near this particular group . . . the South End-Roxbury area. The Black district was only a few miles away from the hospital so it wasn't surprising that we saw this group first. I am speaking now strictly from a geographical point of view.

But the experience of other cities, for example New York, and the experience of the public health hospital in Kentucky, very definitely imply that the minority groups were the afflicted. After World War II there was a rise in the rate of addiction. This rise was seen among the Black, Mexican, and Puerto Rican minorities. This was true in Boston, too.

Then, as time went on, we began to see younger people, mostly Blacks in their thirties and early forties. Then the population of the wards seemed to get younger. We were beginning to get adolescent boys, some girls, who were quite White, and from different sections of the city. First we got them from the East Boston area which is Italian-American, then later from the Hyde Park-Roslindale area which is Irish-American. Recently we have begun to see the Jewish boys from Newton and Brookline and then the upper class Anglo-Americans.

As we face the problem now, we get this cross-section that I have tried to define. Now, there is no ethnic group that predominates. Addiction to drugs is no longer a problem of minority groups. It seems rather to be a problem associated with affluence on one hand and poverty on the other. It is very hard now to make any sociological explanation with regard to ethnogeny, but one can say that one can draw a great number of sociological conclusions on the basis of this widespread activity of drug taking that we all know exists in probably every area of the State and probably in every area of the country at this time. I grant that there are some areas that are harder hit than others.

Since I am a psychiatrist, I originally concerned myself with developing a psychiatric approach to the problem. Consequently, I used the psycho-therapeutic approaches, but I gave that up very quickly. Since then, my staff and I have developed a treatment program which I think takes into account the therapeutic problems we face.

The bulk of these several hundred patients makes it difficult to generalize, but certain features appear often enough, from a clinical point of view, so that it is possible to describe these features. I shall try to describe the treatment problems and how we have attempted to solve them. We have noticed that there is a curious kind of emotional disturbance among these patients. It is what we call a regressive character disorder; that is to say, these people have become accustomed to gratifying themselves in a very primitive way. Drug gratification, I think, is quite primitive. It creates a kind of viscerally centered orgiastic experience . . . at least at first. Certain of the narcotics are associated with some pain; this pain may be physical as in a case of poison ivy or a broken bone or a coronary but more commonly in this group it is emotional pain. These people when confronted with anything that is emotionally painful, be it a pretty girl, a competitive situation, a disappointment, a family problem, a criticism, any situation in life that is the least bit painful, they satisfy or handle it, or not handle it — if you want to look at it that way — by drug taking. This I think you will grant is primitive and regressive behavior.

The character of the individual is further damaged by the pharmacology of the drugs themselves. All addictive drugs create two problems: first, if the drug is withdrawn or if a person cannot obtain the drug, he becomes ill, painfully ill. It may be that if you or I were confronted with this kind of illness, we would be able to face it, but these people are so poorly adapted to handling the problems of pain, they can't face it and are forced (if that's the right word) into repeated attempts to take the drug even when the orgiastic experience no longer is present. They take drugs simply to prevent the pain of not taking drugs. This syndrome presents a vicious circle. To further the problem, with addictive drugs, the pain is solved only by taking increasing amounts . . . brought about by a change in tolerance . . . so that to prevent themselves from getting sick, they have to take more and more drugs. But drugs are hard to get and, consequently, it requires a great deal of activity to obtain these illegal drugs. This situation precipitates the individual into the drug-way of life. This is really a street-way or criminalistic-way of life and is the second problem. If the drug be heroin, for example, the price in Boston is ten dollars per bag. If the person needs three, four, five bags per day to satisfy his drive . . . this means he needs fifty to sixty dollars per day to support his habit. You can see how expensive it is and how criminalistic one has to be unless one is unusually wealthy. The individual must obtain this supply just to prevent himself from feeling sick.

A word about drugs: different ethnic groups use different drugs, but these differences are beginning to break down. The Blacks present a paradox, for though they are, economically speaking, the poorest group of people they use the most expensive drugs. I cannot offer any explanation. Blacks tend to begin their careers with marijuana (this is the great point that the Federal government and the police like to make about the evils of marijuana, but the problem is much more complicated

and they know it) and shift to heroin almost exclusively. Very rarely does a Black take barbiturates or drug store products. He chooses heroin which is completely illegal in this country. There is simply no legal supply and even a physician cannot prescribe heroin under any circumstances.

I mentioned the criminalistic activities associated with heroin. This is the reason law enforcement people are so vitally concerned with drug abuse. This particular group of people who are addicted to heroin has to steal about two to three hundred dollars worth of goods per day in order to get the fifty to sixty dollars from the fence of stolen goods. As a result, there is a tremendous amount of property stealing and property damage associated with drug abusers. You can understand that in a city like New York officials really are faced with a problem of major proportions since there are thousands of people stealing at this rate. These people present a deep-seated community problem which is also a major economic problem in terms of the operation of a city in a large metropolitan area. Boston is not quite this bad, but I think we are only about five years behind New York, and we seem to be doing our best to catch up.

There are other drugs, other narcotics, which are terribly addictive . . . morphine, laudanum . . . . I don't need to mention them all — which are drug store products. They are manufactured; they are legal. I can prescribe morphine, for example, to somebody who has had a coronary or who has broken a leg. Blacks tend to avoid these drugs; Whites tend to use synthetic drug store narcotics. In contrast to the Black group which begins its career with marijuana, the White group very often begins its career with various cough preparations. This was especially true four or five years ago when we saw young people who had begun their drug careers by taking terpin hydrate with codeine or other cough preparations that have about four grains of codeine per four ounces of the cough syrup. They drink this in gulps. They use barbiturates and seconal, which are not narcotics but are sleeping pills, in copious amounts. In East Boston the boys get together, sit around a table, and instead of having a drink hand out pills as if they were jellybeans. These boys get terribly addicted to the barbiturates. Many of them then shift to narcotics and now, in spite of the law enforcement activity that is going on, they have shifted to heroin just like their Black brothers.

It is very hard not to make generalizations in terms of addiction since the situation has changed so rapidly just in the past two or three years. Now more White people are smoking marijuana in middle and upper class circles than ever before. It is obvious that there is a great deal of experimentation both on a post high school and college level.

The form of treatment determines our therapeutic approach much more than the character of the actual drug taker or his criminalistic activity. Drug taking, at least with our patients, begins about the age of 13 or 14 and proceeds until the age of 20 or 21 at which time the individual is in such serious difficulty in one way or another that he is either forced to see us or the police or family call us. At the beginning of the pro-

gram it was the Black who was 30 to 35 years old. Today these people are 19 or 20 years old, and we could easily fill our three wards with 17 to 19-year-old boys plus a few girls; all of whom are severely, psychologically addicted. They come to us at 19. They have wasted six crucial years. They were in college or going to school, getting an education of one form or another, depending upon their intelligence, their social backgrounds, etc. They were studying to become machinists, secretaries, doctors, lawyers, etc. That is what their healthier colleagues are still doing. But these people are doing nothing. They haven't learned anything since they were 13 years old.

It is interesting to note, and I am sure that you as educators will be interested, that many of these people break down at the time of the shift from junior high school to the senior high school; from the school which is probably a little smaller and more personal to the larger more impersonal high school. This is the time when these people seem to take up drugs. On the school grounds one can note the litter of terpin hydrate bottles from which the students drank before or after school. In any event, these youngsters have wasted time; they have dropped out of school by 16 or 17 years of age. Most of the patients in our clinics have not finished high school; therefore, the therapeutic problem becomes one of education. In the last three years, two years perhaps, though I still have my identity as a doctor and as a psychiatrist, sometimes, informally, I think of myself as an educator, albeit an amateur educator because I could not draw up a curriculum if I had to. But I do think along educational lines with specific educational goals.

At the beginning of this talk I mentioned twenty-three per cent of the patients with whom we have worked are doing extremely well, but we can't say that we have cured anybody at all. This group is still addicted. However, they are functioning, educated, addicted people, rather than non-functioning, criminalistic, addicted people. Then, what is the difference? The difference lies in the fact that they do not take as many drugs and, therefore, they control themselves much better. Basically, with them we have been able to focus attention on their need for education; we have been able to help them control themselves while they learn to sit a few hours each day in school. We have methods for testing them. We work hand-in-hand with educators concerned with rehabilitation. We help them train to be welders, machinists, IBM operators, and later we place them in areas which are not too tightly controlled by the unions. These people then have a fighting chance to get started.

But really, the character structure of these people is so primitive that in many instances we have had to start from scratch and first teach them to brush their teeth in the morning! We instruct them about getting up in the morning, shaving, having something to eat for breakfast, at least a cup of coffee, pointing out the acceptable kinds of clothes to wear for particular occasions. This is really basic education not only with regard to student activities but in terms of how to sit down and organize themselves in such a way that they can adapt to the twentieth century;

whether this century, this society is good or bad is aside from the point. People have to learn to adapt themselves to the way things are. It is in this area that we have focused our attention.

Sometimes we feel we are exceedingly successful but other times we feel completely frustrated. It can be very frustrating since so many of the patients' psychological problems center about their reluctancy to work and, in some instances (let us say that the patient has been withdrawn from the drug and is clean) we have actually had to confront them with the ultimatum: If you wish to stay in our ward and use the ward further you must work.

The next step is to get a patient into some work situation. He has to be confronted sooner or later, for we know full well that if he does not work, he will be back on the street, back on drugs, and eventually, get picked up by the police. All this is predictable. Like all stupid criminals, the addicted person always gets caught and ends up going to jail. We've had this experience. On numerous occasions these boys having been faced with the alternatives of work or jail they choose jail. However, we do not stop there. We continue with them; we pick them up after they have been released from jail. Rehabilitation is a long, bloody haul; that twenty-three per cent of the patients have improved is a tribute to the success of the program. One can look at this figure in another way though and say twenty-three per cent of the people were able to take advantage of this particular type of help; twenty-three per cent were well-organized enough so that they could adapt themselves; they could grow as it were.

For the therapists who have been involved, this has been an unique experience: just realizing this facet of community life and recognizing that essentially the problem of drug addiction is not a medical problem. I happen to be a medical man. Recently when I spoke to a group of third-year law students at Harvard . . . and you know how clever they are . . . they asked, "Why does it have to be you, a doctor?" I did talk myself out of a job, but fortunately, there was nobody from the legislature there. Then again, perhaps I'm the only one foolish enough to take it over. In any event, treatment of the drug addicted is not a medical problem. There are medical aspects to it. We do use various pharmacological tricks like maintenance programs to help them along but, basically, the treatment requires an educational approach which involves the whole community. Fortunately, we have had splendid cooperation from most communities.

SMOKING, ALCOHOL AND SEX

HENRY J. GURNEY, HSD

I don't want to relate to you the many facts surrounding the statistics regarding cigarette smoking and consumption of alcohol. What I would much rather do is to provide some food for thought in areas about which you, yourselves, may do some thinking, areas in which very little research has been done. Perhaps research has not been necessary up to this point; perhaps it has been less glamorous than the statistical research that has been done and is quite easily supported. Perhaps these areas really haven't been thought about too much. I'm not sure. Smoking and sexual behavior, and alcohol and sexual behavior I shall discuss separately. I was undecided whether to separate them or not because we find a very high percentage of drinkers also smoke. Nevertheless, I'm going to handle them separately. I'm going to start with smoking and sexual behavior perhaps because smoking might be less associated with sexual behavior.

I think all of you are aware of some facts which will start us thinking about the issue of smoking. Smokers have a seventy per cent greater chance of dying at any age than non-smokers. I think we must agree with these figures. They have been recorded over and over and over. We can no longer deny — any of us who are thinkers — that there is a relationship between smoking and morality. This is presently true only for males. For females, the rate is somewhat less. We also realize some of the general statistics: the more cigarettes one smokes, the greater are his chances for disease or death; the more one inhales, the greater are his chances for disease or death. Stopping smoking does help. There is no longer any question about this. The only question might be: Does the stoppage of smoking reverse damage that has already been done? This may lead to a possible question. There is very little question, however, that once you stop, further damage does not occur. Some damage which has been done — it is now felt — is reversible. Your lungs, throat, etc., may repair some of the damage that has been done by several years of smoking.

There are some things I would like you to consider in regard to smoking and sex; the first problem is that of men versus women smokers. We mentioned before that seventy per cent more deaths occur in male smokers. This is not true with women. Why is it not true in women? Probably the most widely accepted reason is that women haven't been smoking as much or as long as have men. Researchers are finding that women, in trying to participate equally with men in many of the various activities and aspects of living, are now beginning to smoke as much or more than men. Women are trying to establish an equality in many fields of endeavor, socially, professionally. It seems that women are trying to catch up with men in dying and they are making gains. Each

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year shows more women dying from diseases associated with cigarette smoking. The prediction is that in a very few years, women will also be smoking as much and dying as fast as men. This fact is particularly important for younger girls. They strive for equality, to do things that boys do, to do things that men do. This new factor may have an influence; it may not. This striving for equality seems to be a point for consideration.

Another point to consider is the attitude of permissiveness that is so prevalent in society. I think of several things here. When I played in high school athletics, not too many years ago, my coach told the team and anyone else who thought about playing on the team, "If you are caught smoking, you are off the team!" There were no questions; there were no appeals. In fact, if you were reported to be a smoker, you were off the team. I think many of you remember this.

The attitude today, however, seems to be something like this, "If I catch you smoking on the school grounds, during school hours, and if you are not one of my best players, you might be kicked off the team!" This seems to represent a drastic change in attitude. Coaches no longer tell their players, to the best of my knowledge, and I know many coaches, "If you're caught smoking, you're off the team!" This is only one example of the attitude of permissiveness about which I speak. There now seems to be much more responsibility placed on the individual.

I'm not saying whether I personally agree or disagree with this attitude; I'm merely presenting the situation as it seems to exist. Smoking on school grounds was unheard of when most of us attended school. If you smoked and were in school, you made certain that not only was the cigarette out but also that the butt was well hidden behind a bush or tree or hydrant or something long before you entered the school grounds. Today what do we have? I read of a request to put a smoking room in a sixth grade in one elementary school. The petitioners felt they had to have an area where they could smoke in the upper elementary school. I will say that I don't think I can agree with this.

I have tried to average percentages of school children who do smoke. About the best studies can show is that approximately fifteen per cent of junior high children do smoke. The definition for a smoker is, not sneaking one every now and then but, smoking daily. Twenty-five per cent of our high school students are smoking daily. Of those who smoke, it is shown that four per cent of junior high school students smoke more than a pack a day. About seventeen per cent of our high school students smoke more than a pack a day. These figures indicate that smoking is a problem as early as the junior high school. One study done in a Mid-Western school in an economically deprived area indicated seven per cent of their fifth graders smoked. These students were not over-age for their grade, for they had been passed along on a social promotion basis whether they deserved it or not and, therefore, were of the normal fifth grade age.

Another area we should perhaps consider, related to permissiveness, is the parental attitude towards smoking. Sixty-seven per cent of the

parents, in one study, when asked about their children's smoking said, "We don't care! If they want to smoke, it's up to them!" Some parents stated that they had given their children permission to smoke. "We would rather have them smoke in front of us than behind our backs!" I can't agree with this philosophy, but I don't want my children smoking behind my back either. I just don't want them to smoke. I think parents have to take some responsibility.

Why do children smoke? Children smoke for many reasons and we all can list several. If there were one specific reason, one specific cause for smoking, it might be possible to attack that problem and prevent many from beginning to smoke. Since there seems to be no single cause, there seems to be no single answer.

Among a group of several hundred students sixty or seventy per cent were aware of the health hazards. They did very well on the pencil-paper knowledge tests regarding the hazards of smoking, but the final question: "Would you like to stop smoking?" — they all answered, "No!" Not one answered, yes.

The conclusion of this particular study stated, "Parental example rather than parental attitude seems to be a much greater factor as to whether children do or do not smoke." The example that parents set means more to a child than his having been granted permission to smoke.

Another attitude to consider is that of rebellion. One of the reasons given by many students for smoking is, "I'm told not to do this and don't do that." Students respond with, "I'm going to do what I want to do." This is a reason given by the students themselves. "I'm going to smoke anyway just to prove . . . ," — whatever it is they're trying to prove. Another reason given for smoking is that it is grown-up to smoke. This attitude or opinion seems to be losing favor quite rapidly. Smoking no longer seems to make you more of a man or more of a woman.

There is, to my knowledge, no known physical link between smoking and sexual behavior. There is nothing about smoking that would lead to promiscuity; there is nothing about smoking that would lead to any type of different sexual behavior. Some of the factors previously mentioned might indicate an attitude that would lead to different sexual behavior, but there seems to be no physical basis for stating that the use of tobacco leads to more permissive sexual conduct.

We have mentioned stopping smoking. Dr. Willgoose mentioned briefly that about sixty-five thousand physicians have quit. I have adopted the philosophy that if I can help just one student every year to quit smoking, I've done a pretty good job! Any more than that is a bonus.

Alcohol is an entirely different problem in relation to sexual behavior. Alcohol was the first drug to be made and used by man. In fact, alcohol was discovered by accident, and it didn't take man long to realize its potential. When alcohol was first discovered, some thought it was an aphrodisiac — that it would increase sexual desire. This has been found not to be true.

The people in the United States spend annually twelve to fifteen billion dollars on alcohol. This about equals the amount spent on education. Sixty-five to seventy-five per cent of the total population drink. If you are getting your share, you are drinking three ounces of whiskey and six bottles of beer every week.

Ethyl alcohol is the concern. Ethyl alcohol is the intoxicating agent. Methyl alcohol about which some of us get confused is a deadly poison. Ethyl alcohol can be consumed but it is also dangerous. It can become a poison when taken in large doses. Ethyl alcohol is produced by the simple fermentation of sugars which are acted upon by enzymes. The three most popular forms of alcohol are beer, which is a fermentation of grains; whiskey, which is little more than distilled beer; wine, which is the fermentation of grapes or other fruits. Wine, if it doesn't ferment to the alcoholic content desired, has alcohol added. Wine will ferment to about sixteen to eighteen per cent. You can buy wine that is twenty-two, twenty-six per cent and even up to thirty per cent. Wine stronger than sixteen or eighteen per cent has had alcohol added.

It might be interesting to understand "proof." The alcoholic content is about one-half the stated proof. One hundred per cent whiskey would be fifty per cent alcohol. A little history about this: The way proof was originally determined in England was to put gunpowder over the top of whiskey and light it. If the gunpowder exploded, it was about fifty per cent alcohol. This was proof that it was good enough to sell! So proof has come to mean about fifty per cent alcohol for one hundred proof.

The quality about ethyl alcohol that we should understand is that ethyl alcohol and water share the ability to be readily absorbed by the body. Ethyl alcohol and water are soluble, one in the other. They mix readily and thoroughly. Our body will absorb water; it will also absorb ethyl alcohol at the same rate and to the same degree. All the alcohol ingested is absorbed into the body within 45 minutes after the discontinuance of drinking. Absorption can be delayed by food in the stomach. The word delay is important particularly when talking about novice drinkers. It does not mean you are not going to absorb the alcohol; it means that you only delay it. If you drink alcohol, you're going to eventually pay for it! Diluting also delays absorption. Again, it will eventually be absorbed. The dryness of the drink can accelerate absorption. Dryness means only lack of sugar, i.e., the drier the drink, the less sugar. The drier the drink, the more readily it is absorbed.

Altitude also increases the rate of absorption. The major airlines have now limited customers to two drinks per flight. The reason is this: the person who can drink four or five on the ground and apparently be in pretty good condition, at thirty thousand feet with four or five drinks, can become a problem.

Being an habitual drinker also accelerates absorption. The person who is an habitual drinker absorbs alcohol at a faster rate. This is contrary to much public opinion. This is not to say that the habitual drinker cannot handle alcohol. He may be able to handle it better because he

has learned to compensate. The impairment in the habitual drinker is the same as in the occasional drinker; for example, if the habitual drinker is picked up on suspicion of drinking while driving, he walks and talks very slowly and very carefully. The novice drinker talks more than normally. The habitual drinker has learned to be quiet when the officer stops him to ask him a question. If the habitual drinker is asked to walk the white line, he spreads his feet wide apart, walks very slowly and he doesn't get the weaving of the novice drinker who tries to walk heel-toe, heel-toe.

Once alcohol is absorbed into the bloodstream it is distributed throughout the body in equal proportion to the water in the body. One can take a piece of tissue from the end of a finger and tell how much alcohol is in the brain because it is known how much water is in the finger and how much water is in the brain.

Alcohol causes blood vessels to dilate and the body to lose heat. I mention this because it is often thought that a drink is warming. It is the worst thing to do to warm up!

The effects with which we are most concerned are, however, the effects of alcohol on the central nervous system. Small amounts of alcohol — even minute amounts — impair judgment. No matter how small the amount of alcohol, judgment is impaired. The particularly sinister fact is that the person doing the drinking does not realize the impairment. In fact, he may feel his sense of humor, personality, and wit are sharpened by alcohol. They are not! Judgment is impaired by any amount of alcohol. Of course, the greater the amount of alcohol, the greater the impairment. Gross effects such as motor coordination, lisping, slurring and other signs of inebriation do not occur until the concentration is greater.

It has been estimated that fifteen per cent of the mileage driven is driven by drivers who have been drinking. These fifteen per cent of the drivers have fifty-five to sixty-five per cent of all fatal accidents, about three and one-half to four and one-half times as many as they should be having. Certainly this is convincing enough to indicate the dangers of drinking and driving.

Another problem of concern is the combination of alcohol and drugs. By drugs, I mean common barbituates, sleeping pills, etc., found around the house; yes, even aspirin. The danger of combining aspirin and alcohol is not only as great as the sum of the parts but possibly much more potent. Medicines taken before or during drinking can make a significant contribution to the inability of the person to perform any given task.

Another thing I would like to mention is that which can be identified as psychological drunkenness. Studies have shown people exhibiting all the symptoms of drunkenness on very small amounts of alcohol. These same people will show no ill effects with greater amounts of alcohol in the absence of social stimuli.

Attitudes regarding drinking have changed. I refer now to many of the same points that I made about smoking. I think that coaches, for

example, who catch players drinking, may kick them off the team because this is a more serious offense than smoking. But there certainly has been more permissiveness regarding alcohol and athletes. There has been more open drinking in the homes. Two or three colleges have added courses in social drinking.

There are two thoughts about sexual behavior and alcohol. Very often a girl says, "I would never have done it had I not been drinking." Most of you have heard this or heard someone tell a similar story. This is an attitude on the part of the girl. Her statement may be true. Let's look at it another way. Perhaps this is something the girl wanted to do anyway, and since she was drinking, she now has an excuse, for she can blame drinking for her actions.

Does drinking lead to sexual promiscuity? There is little question that it does. Whether it is the cause or the effect is not important. The fact is the two seem to go together. Either people are promiscuous because of drink, or people drink because they desire to be promiscuous. But, in the absence of alcohol, she might have remained chaste. It is difficult to realize a person can drink to the extent where he will not realize, or will not know, what he is doing sexually. There is still a law on the books in this state and in most states that a woman may consent to intercourse under the influence of alcohol and still charge the participating male with rape, even though she is of age and gave her full consent. Maybe it is an archaic law, but apparently it was felt at one time that a woman had no control of herself under the influence of alcohol. I think we have shown this not to be true.

Males use alcohol to arouse sexual desire in females or, at least, to break down female resistance to sexual advances. We all have known fellows who carefully plan to get a girl drunk with the idea that he then will have a much greater chance for sexual fulfillment with the girl. Whether this kind of planned attack works or not is something else again. Other things being equal, the effect of alcohol on the central nervous system is directly proportional to the body weight. Therefore, when the average 160-pound male and the average 110-pound female try to have drink-for-drink, which one is going to be in trouble sooner? The girl is. The girl doesn't want to admit that she can't drink drink-for-drink with a man so she drinks more than she can handle.

An interesting study concerning the personalities of drinkers and non-drinkers was undertaken at Washington University with some seven hundred people. Personalities of drinkers and non-drinkers differ in many respects even when they are not drinking. Drinkers (this is when they are not drinking) tend to be more selfish and materialistic than non-drinkers. They are, however, more tolerant, more affectionate and more impulsive. Maybe this type of person tends to be more promiscuous, and alcohol might have nothing to do with it. But, drinkers are moodier, less optimistic, more subject to boredom and restlessness than are non-drinkers.Three out of four drinkers smoke. One out of ten non-drinkers

uses tobacco in any form. Drinkers prefer games of exciting nature, e.g., parties, poker, boxing, wrestling. Non-drinkers prefer concerts, flower growing, walking, etc.

A brief comment on being driven to drink. Most sociologists and psychologists indicate drinking brings about a problem on which you may now blame your drinking. It is not the problem that causes the drinking; it is the drinking that causes the problem. Drinking seldom, if ever, solves any problem.

A comment on women alcoholics: Some authorities now state that there are as many, some even state there are more, women alcoholics than men alcoholics. The greatest increase has come in the suburban area where mothers have children now in school. There no longer are children at home. The husband has gone to work and the children have gone to school. What has mother to do for four, five or six hours? She turns to the bottle and by nine or ten o'clock in the morning is well on her way. If she stops drinking shortly after that, she is sober by the time her husband and children get home so no one knows anything about her drinking. These people form a tragic group of alcoholics. We are also finding that it only takes a woman on the average about two and one-half years to achieve alcoholism. On the average men have to work at it from ten to twelve years. Averages perhaps mean very little in this case, but generally women become alcoholics more quickly than do men.

Is alcohol a depressant or a stimulant? This is a question children often ask. The best way to answer is that it depends upon the person. It might even be different for the same person every time. There seems to be no clear-cut answer as to whether people become depressed or relaxed by the use of alcohol. Some personalities react the same way every time. We have all known people who with a few drinks become surly, ugly, argumentative, and belligerent. We know others who go into a corner and seem to want to fall asleep. The reaction of the majority of people is somewhere in-between; they react differently under different social or personal conditions. Alcohol does tend to exaggerate an individual's particular emotional condition at any given time.

One last thought. A very common question from children is, "How can I go to a party where there is drinking and refuse a drink when it is served?" We've all been in this situation; someone says, "Have a drink . . . just one . . . be part of the group." How do you help a youngster refuse a drink without losing face? The best suggestion to a young person is to tell the absolute truth. He can easily say to his host or hostess, "I'm sorry; I'd like a drink but I'm allergic to alcohol."

V. D. AS A MEDICAL, SOCIAL AND SEXUAL PROBLEM

NICHOLAS FIUMARA, M.D.

Christmas time is a time when one thinks in terms of fun and festivities. Who wants to talk about sex and V.D.? However, let us not kid ourselves; as a consequence of our national institution, the Christmas party, the Public Health Department has already seen venereal disease, and it isn't even Christmas yet! The Christmas parties of last week and the week before have resulted in venereal disease, and the Public Health Department is already treating these patients.

No, I am not against the Christmas party. I believe firmly in the Christmas party. I advocate the Christmas party, but I say, "Bring your wife or your husband along and avoid some of the problems that occur after every Christmas party." We adults, like our youngsters, don't learn from others' mistakes; sometimes we have to commit them ourselves and learn the hard way!

This afternoon I hope to give you a perspective of the whole problem of venereal disease because you teachers and parents have to know what the problem is. You have to know the truth so that you in turn can relate this to your youngsters. You have to know about the problems of sex for your own sake and so that you may understand what is going on in the minds of our young people. In our day we said that high school was the danger period for sexual promiscuity and pregnancy. Today these problems are no longer just in the high school; they are in the junior high school and sometimes even in the grade-schools. During the month of November the Department of Public Health treated a six-year-old boy with gonorrhea. Sexually acquired gonorrhea in a six-year-old boy! He got it from a fourteen-year-old girl who in turn gave it to an eight-year-old boy. We are going to write this case up for the medical literature because we think this is the youngest boy with acquired gonorrhea. The problem exists. I would like to discuss the disease as it exists and some of the things that are being done to control it.

First, let us put the communicable venereal diseases into perspective within the constellation of communicable diseases. Venereal diseases rank first above all other diseases! This is something we are not aware of but should be. In these United States there are 1,200,000 new cases of gonorrhea a year or 100,000 cases a month. There are 120,000 new cases of syphilis a year or 10,000 cases a month. These figures give an idea of the size of the problem as it exists in the United States today.

Measles is a disappearing disease, and within the next year it should be completely eradicated in Massachusetts. Thanks to the vaccine, there has been a 98.5% reduction in this disease in the last two years.

Now, let us talk about syphilis because the Department of Public Health has been preoccupied with this disease. Syphilis is one of five venereal diseases. It is a disease that kills people, and even if we diagnose

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it early, it still definitely diminishes life expectancy. Syphilis, therefore, is a killer and a shortener of life. The first two stages of syphilis, the primary and secondary stages, are the most infectious. Syphilis may be spread in any one of five methods: first, by sexual exposure to the initial lesion. The primary lesion appears at the point of exposure, and since this disease occurs most frequently through exposure, the lesions are usually found on the genitals. Second, syphilis can be acquired by kissing people with lesions in the mouth or the oral pharynx. Third, a syphilitic mother can infect her baby in utero. Fourth, syphilis can be contracted via a blood transfusion — you can see the wisdom of the law in good medical practice which requires that every blood donor must have a negative blood test. Lastly, syphilis can be acquired by accidentally touching infections.

We who are interested in control problems are preoccupied with stages, we can cure the disease and there will be no sequelae. There may be a lot of emotional sequelae, but there will be no organic sequelae. The control program, therefore, is aimed at the finding and preventing of primary and secondary syphilis. How successful have we been? We were successful following World War II and then, in 1955, primary and secondary syphilis plateaued-out. Beginning with 1958, the incidence of primary and secondary syphilis began to climb, and it has continued to climb since then. The result is that since 1958 there has been a 240% rise nationwide in primary and secondary syphilis. What about Massachusetts? In Massachusetts we reported in January 1968 a twenty per cent rise in both gonorrhea and syphilis . . . a twenty per cent rise in one year! It is always important to know why it happens. The "why" is something that we don't ever want to forget because, as professionals, we are required to think, and we are supposed to know why we are doing the things that we do.

The rise in the incidence of syphilis is definite. Where is the problem? One cannot just be concerned with Bedford or Massachusetts. One cannot be concerned with our Puritanical state alone. One has to be concerned about the different regions of this country and the country as a whole. One has to know what goes on in other countries, too, because about twenty-five per cent of all our infectious venereal disease is imported from other states and other countries. Heaven knows how much we export! We are now in the Christmas season. There will be Christmas tours and Christmas vacations. People are going all over the United States and all over the world for vacations and will be bringing back venereal disease. We are transporting some of ours into other countries and other states. When winter comes, we not only import typhoid as we did from Zermatt in Switzerland, but we also get venereal disease with the winter sports. We Americans are one of the most mobile peoples on the face of the civilized earth — twenty-five per cent of us move from state-to-state every single year — and with this mobility comes a loss of identity and anonymity. When some of the social restraints are removed, many people behave in a way they would not normally behave.

The highest rates of infectious syphilis in America are along the East Coast, the Gulf Coast, the West Coast. One can look at a map of the United States and draw a line from Delaware across the United States. South of that line is where there is the highest concentration of infectious syphilis. Of course, syphilis is also a disease of the metropolitan centers. Statistics show there is five time more gonorrhea in the city than in the country and three times as much syphilis in the cities as in the country. But the rural areas are not immune to V.D. and never were. The state that leads the United States right now is Alabama, followed by South Carolina and then Florida, now in third place, was once number one. It is obvious that when people go to Florida they do things other than retire. Or perhaps in their retirement they have opportunity to do other things.

We have another problem in relation to this. We have an increasing problem right now in Massachusetts of a geriatric venereal disease — venereal disease among the elderly — those sixty-five years and older. Basic to this whole problem of gerontology is the lonesomeness that goes along with being a widow or widower. This lonely life evidentally can be relieved by sexualy activity.

Now, who gets V. D.? First, the young adult, twenty to twenty-four; next, the older adult, twenty-five to twenty-nine; third, the teenager, fifteen to nineteen. It is interesting to note in this regard that when a teenager goes into adolescence he is bacteriologically sterile; consequently, as long as young people cohabit with each other, they don't get venereal disease. The girl may get pregnant, true, but she will not get venereal disease. Only when a teenager strays from the peer group to an adult is he exposed to venereal disease. Then he comes back to the peer group with venereal disease and infects the group. But the teenager ranks number three in respect to rates of incidence.

Syphilis is also a disease of childbearing females. It is bad enough that a woman gets infected; the evil is compounded when she gives it to her unborn baby in-utero.

There are ten times as many cases of gonorrhea as of syphilis. Infectious venereal disease which consists of primary and secondary syphilis and gonorrhea ranks second among teenagers, fifteen to nineteen years of age; therefore, we are concerned about introducing courses about venereal diseases to seventh, eighth, and ninth grade levels. At the seventh grade level students are about twelve years of age . . . going into adolescence. At the ninth grade, they are fourteen to fifteen and we are concerned to give these young people information in advance of their need to know. Today we know young people experiment with sex at a younger age level than people of our generation did. It doesn't require a study to determine this. All one needs to do is to talk to them.

All patients who have venereal disease have contacts. This is how the disease was acquired in the first place. In 1950 the average patient with infectious syphilis named three different sex partners; in 1960, four different sex partners; in 1966 again, four different sex partners. Who are these sex partners? Prostitutes? Today a prostitute cannot make

enough money during her working years to provide for her old age. Why are we driving the prostitute out of business? Is it that there is an increase in religious fervor in the community? The answer is No! We are confused today with this modern morality. Is it that the police are smarter than we think they are? The police will enforce only those laws we, the citizens, demand. We don't require that they enforce the laws against fornication or adultery except where it involves a minor child. Other than that, they look the other way because WE don't want them to enforce the laws. Then, why are we driving the prostitute out of business? It is simply because of the laws of supply and demand. Why pay for something when you can get it for nothing! In 1966, three per cent of venereal diseases were associated with prostitutes.

In the last five years there has been an emerging problem of homosexuality. Whether this represents an increase or an apparent increase is debatable. Certainly our culture seems to be more accepting of homosexuality. In 1966, one-sixteenth of all our patients with infectious venereal disease were homosexuals. The average homosexual with infectious syphilis names ten different sex partners. It is the heterosexual who named four partners. Teenagers average six different sex partners!

This gives you a little idea of the problem that we in the Department of Public Health face. We say very glibly that venereal diseases are a medical problem; but we must recognize that they are also a family problem, a social problem, and a moral problem, but nobody but the medical profession does a thing about them! Too long has the medical profession been saddled with this problem, and we are now talking back and saying that it is also a problem which we share with you. We will do our part . . . the medical part . . . but society has to do its part, too. We are, therefore, concerned about the role of society, the role of the home, the role of the church, the role of the school. These institutions all have active roles to play in the prevention and control of venereal diseases. Let us not hand it all to the medical profession. Doctors have been the scapegoats too long, and they are not happy in that particular role. They have done more than their share. Gonorrhea can be cured with one injection despite the fact that the Vietnamese strain of gonorrhea is now in Massachusetts as well as on the West Coast. Doctors can diagnose and can cure, but in the area of prevention they are not so effective. In this area the family, the school, and the churches must assume responsibility.

Sexual promiscuity is not a monopoly of the lower social economic group. It never was. Today the rate of increase of venereal disease among Whites is rising faster than among non-Whites. The rate of venereal disease in the suburbs is rising higher and faster than that of the cities. The rate of venereal disease is rising faster in the practice of private physicians than in clinical practice.

In Massachusetts, there was a twenty per cent rise in infectious venereal diseases for the first eleven and one-half months of 1967 as compared to the first eleven and one-half months of 1966. The reasons for this are many. First, the Department of Public Health started a

propaganda campaign the winter of 1967 with WBZ-TV and the group W stations. A number of things have happened as a consequence of the slogans — "Venereal Disease is Not a Dirty Word, It's a Disease!" "V.D. is Very Dangerous!" "It's now eleven o'clock, do you know where your children are?" This is a public service of WBZ-TV and its group W stations that was broadcast through New England and the Middle Atlantic states. The full program of public education included six documentaries, two of which were made by the Department of Public Health. These programs have helped to make people aware of the problem as it exists. They are not designed to frighten but to tell the truth.

Like an iceberg, most of this problem is below the surface: only ten per cent of cases are reported. In 1966, forty-five per cent of known cases of syphilis were reported, therefore, we guess at the approximate number which lie under the surface. People have been alerted to the problem through TV programs and, as a result go to one of the 22 clinics in the state which are run by the Department of Public Health. The Department has been flooded with telephone calls, and we have sent out thousands of pamphlets about V.D. to people who have written to us. These programs therefore, in part account for some of the increase in venereal diseases in 1967. However, it doesn't account for all of the increase because prior to the propaganda campaign, which began the latter part of March 1967, we had already noticed a sharp increase in syphilis and in gonorrhea in the first three months of this year.

Gonorrhea is always acquired sexually via heterosexual or homosexual relationships or perverted or normal sex. A discharge which is characteristic occurs one day or as long as two weeks, but usually three to five days after exposure. One injection of penicillin accounts for a cure-rate of ninety-seven per cent. A diagnosis can be made within two minutes by smears, forty-eight hours by cultures and, before the culture report is back to the patient, the patient is cured. Many patients are dry in twenty-four hours. Many of these patients will go out with their girl friend the next night, have another exposure, and come back to the clinic with fresh gonorrhea. We call this ping-pong gonorrhea. Only until we catch up with the girl friend and sterilize her with penicillin can we stop the ping-ponging of the organism.

In time, unless we develop a new antibiotic these patients will not be able to be cured without hospitalization. The reason for this is that presently we are getting a resistant strain of gonorrhea out of Vietnam which requires 3.6 to 4.8 million units of penicillin. Once we have to treat patients with a dosage of penicillin in excess of 4.8 million units we no longer can treat them in the office or outpatient department. Unfortunately, however, hospitalization costs money that we presently do not have.

A doctor who treats a syphilitic patient always wears rubber gloves, for the possibility exists of contracting syphilis by handling a lesion. Our skin is peppered with billions of openings of the pilosubaceous ducts and the sweat ducts. The average diameter of a sweat duct opening

is 2 microns; the average diameter of a spirochete is ¼ of a micron; so, 8 spirochetes can march arm-in-arm down a sweat duct opening; there does not have to be a break in the skin in order to contract syphylis by touching a lesion. A chancre represents the first stage of syphilis. It is a sore that does not hurt and does not itch. However, the neighboring lymph node becomes enlarged. The good Lord must have had a sense of humor when he gave us such a lethal disease and yet took away the pain.

Are condoms effective as a prophylactic against venereal disease? Against gonorrhea they do work provided: 1) there be no preliminary sex play; 2) the condom must be intact before use; 3) the condom must be intact after use; 4) the condom must be put on correctly; 5) the condom must be taken off correctly. If all of these five conditions prevail, a condom will protect against gonorrhea. However, even if all of these five conditions exist, a condom does not fully protect against syphilis because a condom protects the part it covers and nothing more. It covers the head and the shaft of the penis; it does not cover the base of the penis or the synthesis of the thigh areas which are bathed with the secretions of the female during the sexual act. Today therefore, nobody in the United States advocates the use of condoms as a prophylactic against venereal disease, completely apart from any moral or legal consideration, for they just do not work!

Unfortunately, in the female, the syphilitic chancre frequently appears on the cervix or within the womb itself. Therefore, unless a doctor performs a pelvic examination he is apt to miss it. Syphilis can be cured in the secondary stage when the patient develops a rash and becomes sick.

The primary stage lasts three to four weeks. Then the patient develops symptoms which can be grouped into what is called a flu-like syndrome complete with headache, nasal discharge, sore throat, and generalized aches and pains. In addition, the patient develops nodes all over his body, and the lymph glands become enlarged. A rash also appears. Fortunately, the rash of secondary syphilis has some specific clinical signs: it is all over the body, both skin as well as mucous membrane surfaces and has a special predilection for the palms of the hands and soles of the feet.

Times have changed a bit for now if a youngster comes to the clinic we do not have to get permission from his parents to examine him. Under the State law, we have authority to examine and treat any minor without the knowledge and consent of his parents. Youngsters know this. But some years ago when we had to say to a minor, "We cannot treat you without the knowledge of your mother or your father," we would never see them again. Young people talk to each other. We parents don't talk to one another but our children do; therefore, word got around the community, "Don't go to the clinic. They won't examine you without the ole man or your mother present!" So they didn't come to our clinics. Consequently, we changed the law. Today we are authorized to examine minors without the knowledge and consent of the parents.

STANDARDS OF DATING BEHAVIOR

LUCILLE PALUBINSKAS, PH.D.

My credentials are so skimpy I want to confess them lest in the question period you find me out! I don't stand before you really as an expert in the field of sex education. I am a teacher of psychology. While it is true that I have taught child psychology and do teach the general introduction to psychology, my heart is mostly in the field of statistics. That doesn't have much to do with sex education, but I do happen to have a very good friend, Donald McLean from Winchester. Donald McLean, I am sure you know, has run a series of sex education lectures given by various churches throughout the Greater Boston area. It is the "Fit-to-be-Tied" series which is conducted for four consecutive Sundays, usually within the church setting.

The first Sunday, the youngsters see a film and write down the kinds of questions, particularly biological questions, that they wish to raise with doctors from their own community. On the third Sunday the doctors divide the youngsters in groups according to age and sex to answer their questions. On the fourth Sunday, the minister, rabbi and priest join together to try to present the spiritual side of the question of sex education and dating. I have omitted the second Sunday, for this is the time Dr. McLean asks me to participate. I usually tell him he asks me because the doctors can't figure out the answers to the questions right on the spot; therefore, they have to get together and check with him to find out what they are supposed to tell these young people. So for the second Sunday, they invite anyone they can get! These are my credentials!

A psychologist, a sociologist or a social worker might conduct that second Sunday session. It is really quite a frightening experience to stand up in front of today's young people and talk about dating and boy-girl relationships. Their attitude usually is, "What could anyone that age know about anything . . . I mean not anyone over thirty, but when you get to be over forty, or hit forty-five, well, really now, that's going a little bit too far."

It is a tough job to stand up in front of those young people and attempt to discuss boy-girl relationships; therefore, what I'd like to do now is to tell you the kinds of approaches I have used with the young people. I don't know whether they're good; I don't know whether they're bad. But I can tell you what the kinds of questions have been I have tried to raise and why I have taken a particular approach with young people. The questions arise out of my own experience with the generations of college students that I have seen. I have taught at Tufts since 1952, and before that I taught in Iowa. A great many of them come to my office and I have spent many, many hours with the college generations that I feel have changed a great deal since 1950. I think every four or

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five year there is a real difference . . . not a difference in sex mores or anything as sweeping as that but a difference in terms of what is in and what is out, and what the latest symbol of revolt really is and means.

I would be happy if you have the time, and if you have questions, to talk a little bit about college students because in the back of your heads, naturally, is the notion that what you do in the 5th, 6th, 7th, or 8th grade, and certainly in senior high school, is really attempt to put a good sound basis under the young person in preparation for the time when he will leave and go out into the university environment or out into the work environment which has its own rules and regulations as far as sex behavior is concerned. Those of you who have youngsters in the elementary school may quake at the thought of their going on to junior high school, but that is nothing to the quaking of the junior high school parents when they think of their youngster in senior high school and in college. With the kinds of things one reads in the newspapers about behavior on college campuses, it is no wonder that parents are concerned.

What do I talk with young people about? Well, I try to place dating, the process of dating, in some kind of perspective. Some people, especially mothers, act as if dating were a sacred thing in and of itself. Dating has its own rules and regulations and when people are dating, suddenly certain parts of our culture just come to a grinding halt. Mothers, particularly, tend to look forward to the dating period; especially, as far as their daughters are concerned, and to a lesser extent their sons. It has been mothers, rarely fathers, in our suburban communities who have pushed young people to date earlier than the young people are ready to date. Now, no mother says to herself that she pushed her child into dating early. No mother would ever recognize that she did it. But she does comment about the fact that Johnnie is so quiet, or Marianne is not very social or Cindy Lou ought to get some experience, etc. Mothers have ways of rationalizing ideas of this sort to themselves.

If you were a man from Mars and came down to earth and observed dating in suburban communities in contemporary America, you might at first glance say "Ah, this is related apparently to the sexual behavior of these earthlings because we notice that on these dates there are male and female combinations, and it looks as if some of these male and female relationships persist so that some people become engaged and marry each other and then produce other little earthlings." But, what the man from Mars might not immediately be aware of is that in many suburban settings, dating has more to do with social prestige, with social class, with social climbing, then it has to do with sex, per se. These things get very mixed-up in the minds of both parents and young people. Dating does relate to sex but dating also relates to the game of social success which is very much the pride of our suburban community. In a given suburban community, young people go into the dating game (if you want to call it that) sometimes looking for love, affection, and attention; sometimes looking for sex experience.

I can separate those two ideas, for I think they are separated in the minds of many young people. Others see dating simply as an opportunity to exploit other individuals in terms of their own social success.

Dating isn't really all about love and marriage and sex. Some dating is about whom you're seen with, under what circumstances, and how this reflects the social standing of the individual in a given high school, and even the social standing of the parents. I think we have to keep this in mind if we are going to be honest about dating habits, for we have developed a pattern of dating behavior in which we have asked for all kinds of trouble.

There are many societies in which courses in family living are not needed; maybe they still would be a good idea, but for a minute, let us take the view of the man from Mars. In many countries the culture takes care of the problem. What do I mean by that? There are some societies which are extremely rigid in their notions about sex. They have attitudes that young people shouldn't be trusted together after the age of puberty. They feel young people have to be watched at all times for they are not trustworthy and never will be. Biology is simply too strong, so young people must be guarded. If you don't have enough guards to go around, then you just guard the girls. There are entire cultures that have been developed upon this point of view.

Now, you may say that that kind of behavior or those ideas existed in the olden days. It is quite true that in our grandmother's and in our great-grandmother's day, ladies of certain social classes were heavily guarded. They were chaperoned. No young woman of good character would ever be with a young man when she was not chaperoned. The Victorians were very repressive about sex. Actually, however, they were not so repressive. Maybe they thought that sex was a pretty strong drive and hence adopted this attitude: Watch out for these young people; don't trust them for a minute! If a young man comes courting, leave the door open. Of course in this type of culture the idea of a young lady going out unchaperoned . . . in a horse and buggy in those days or in a car today . . . with a young man would be impossible! She would have to be accompanied by her mother or her aunt or somebody. The Spanish custom continues in South America for young women of a certain social upper socio-economic class.

I can imagine that there are some people in this room who are of a generation in which they were watched a lot or maybe who lived in a time when everybody wasnt being watched, but whose mother or father happened to be a watcher. Their general attitude probably was, "I don't care anything about all this sex education bit. As far as I'm concerned, we watch and guard and protect our young people." Then there is the other point of view; I turn to lovely Samoa for this. What was it like on Samoa? Allegedly, according to Margaret Mead, sex behavior among young people was very free. It was not uncommon for all the young people in a small community to have very extensive sexual experiences before marriage. It was considered to be just an aspect of life. But,

at the same time, any children who arrived on the scene as a result of these unions were readily accepted into the society. There was no question of illegitimacy.

What happens in America? We picked a pattern somewhere between the repressive and permissive. We have a pattern in which watching young people is practically taboo. We must trust our young people. We allow our young people plenty of freedom. They have plenty of money . . . they don't think so, but we know that they have a lot more money that we had as youngsters. They have tremendous mobility, but no chaperones. In our society, young people are on the honor system. But, we have absolutely no place in our society, an absolutely closed book in the middle class, for any child who is born illegitimately. If young people do engage in sexual experiences outside of marriage, why don't they take some birth control precautions? They don't because a girl isn't supposed to get pregnant outside of wedlock; therefore, the whole problem is never openly discussed. An individual can never get the straight-forward kind of information that he needs.

Let us add another component. What is our criterion of success in our society? Of a job you might say money, but I mean success in interpersonal relationships. If I ask you to tell me in one word what you with for your children, what would you tell me? One word. Happiness.

Now, think of that as a criterion! He is the one for you because you are happy with him! She is the right girl for you because you are happy with her! You two should marry because you are happy! You bring up a family, and you want the children to be happy. What's the matter with it? It is an impossible criterion! It is as simple as that. Nobody is going to be happy all of the time; therefore, everybody is going to feel that somehow or other in their interpersonal relationships, in their marriage, and even in their jobs, they will fail because they won't be happy all the time. We have these romantic notions in our society that if you marry the right person, if you fall in love with the right person, you will be happy. Of course you won't be happy, so what you are going to think is that the person was the wrong person for you. You never turn around and blame the criterion of happiness and say what a stupid goal to have. It is just as stupid a goal to have for your children.

How did we develop such an idea . . . an idea to which we are so very dedicated? We think there are experts who can give us a battery of tests and thus help fit us into the right job. There are marriage counselors who can sit down with us and our mate to help us work out our problems. There are child guidance experts who can wave the magic wand; turn our relationships into "happy" ones. But this just isn't true, even though it is nice that we can think that way. We have a lovely culture. We're wonderful, lovely and kind people who want only happiness for each other. We just happen to be doomed to a lot of disappointments because happiness doesn't happen to be a way of life that is very prevalent. I think one should look more realistically at what

one really means by happiness, and be a little more specific with young people about the things one thinks contributes to happiness. It seems to me that this is what is important.

Let us look into the microcosm of the family. Let us imagine we are in a family situation in which the children are in junior high school. We have a boy and a girl and a mama and a papa. A question relating to dating comes before the family council for some kind of discussion. Let me try to give you a little picture of why a mother, father, son, and daughter are never going to see problems that touch on the subject of dating in quite the same way.

The daughter will tend to be extremely idealistic about dating, love, and romance because her head has been filled from the time of her early girlhood with very romantic and glamorous ideas about love and marriage. She is, if she is in the 7th, 8th, or 9th grade, just longing to fall in love. In fact, she's already fallen madly in love with the camp counselor the summer before who, it turns out, was even a female, to make things seem even stranger. But she is burning with emotion; ready to fall deeply in love with the most unlikely creature that you could ever imagine. We laugh and we smile because we can remember when we were like her, but don't sell short the passion, the devotion, and the love of that individual because it is the same happiness, the same emotion, the same love that she will give one day to her own family and to her own husband. They just happened to be turned to the most unacceptable object at the moment.

The son, on the other hand, has other ideas. The typical junior high school boy, when it comes to dating, is usually being forced into whatever he is doing by his mother, by the girls in his classroom, or possibly by his peers, so that he is a reluctant dragon. As far as he is concerned, this dating business and this boy-girl stuff is just terribly embarrassing because this has to do with sex. He is certain dating has something to do with sex and he is sure that sex is not a very reasonable topic to discuss anywhere near parents, or anywhere near girls for whom he has a reasonable amount of respect. It is bewildering to a junior high school boy with the ideas he has about sex. The notion that his mother would want him to go to a party with girls who play kissing games is very, very confusing. When he is a little older, in his mind there may be a real separation between the kind of girl with whom sex behavior is permissible and the kind of girl with whom it is not. I suppose in some cultures where this attitude is clearly defined it was easier for boys. In our society, it is very difficult for a boy to figure out which kind of girl any given girl is. He is always concerned and worried because sex, as he thinks of it and as he knows it, can't seem to have too much to do with what his mother and his sister seem to be talking about.

Now, let us look at mama. Mama is all a-flutter over the dress that her daughter is going to wear. She is all a-flutter over the little girl the young man is going to take out because she sees this dating as very important in terms of social success. Also, she is a bit smug about her son and her husband because, as Freud pointed out, boys, during the

elementary school years, go through what is called the latent period in which they pretty well turn their backs on the world of women. Then when the boy begins to shave, or to use underarm deodorants, or whatever the signs of the times might happen to be, most mothers become smug about the notion that girls are not so bad after all. The son who really treated her before like a glorified hotel keeper, meal-getter and finder-of-lost toys, now realizes that women have some real value.

The father's plight is the saddest plight of all. Let me explain. In the first place, the mother is absolutely no help. She seems to be egging the children on. When the father says anything, the mother usually laughs at him. If he is very stern and not the kind of father the mother can laugh at, she simply goes behind his back, and he knows this. Now the father sees his son going into junior high school or senior high school where how he does in school becomes terribly important to the father. He wants him to go to the right college, choose the right profession, marry the right girl, but suddenly the youngster goes girl crazy. The father is not really opposed to the boy's liking girls. His boy should be a normal, healthy boy, but basically, the father feels there will be plenty of time for girls later. His own experience taught him that.

When the boy becomes like a limp rag over the subject of girls, the father's reaction is usually one of disgust. His reaction to his daughter's actions is sadder yet. I suppose that every man, when he marries, sees his bride as the epitome of womanhood. But living together, day after day, after a while she no longer is an ideal. Then if they have a girl, and little girls are beautiful creatures, charming to fathers, and just naturally appealing, once again the father begins to dream his dream of the perfect woman. While she might be running around in blue jeans, he still has great hopes that she will be the woman that obviously the mother isn't! When this girl goes boy-crazy and starts running around after the acne-covered creatures who can be up to no good, it practically breaks the father's heart. What does he do? He does the only thing he can do. He can't lose his ideal of womanhood, so he blames the mother, feeling that if she had brought that girl up properly, this kind of nonsense would never happen!

To note how differently members of a family react to a simple situation, let us take for example the simple mini skirt. A young girl in a suburban community comes downstairs in a mini skirt. Her father, her mother, and her brother look at her. The mother sees nothing wrong with the mini skirt per se unless it isn't the thing to do in that particular town. She is concerned with how the skirt fits, the color, etc. The brother is pleased that the other girls are wearing mini skirts but is embarrassed that his sister wears one. The father, on the other hand, feels that any mother who allows her daughter to dress like that is heading for trouble.

If a family can be in such conflict over a mini skirt, it's no wonder that there really is so much tribulation over dating patterns. It's no wonder that if you try to have a sensible discussion about what time of night a 15-year-old boy ought to come in, you almost can't have

a sensible discussion because whatever time of night you decide on, and no matter how democratically you decide a point, the meaning of that decision will be different to mother, to father, to boy, to his girl friend, to his sister, etc., because dating patterns are very deeply involved in our notions about some of the most important relationships that we have . . . family relationships.

Young people try to act at any given age as though they invented dating. They are in a situation in which they must separate themselves from mama and papa and develop their own lives and their own values. It is perfectly natural they should do so. But they can't quite because we are all the products of the home in which we have been brought up. It is almost impossible for a family to sit down and have a calm discussion on any topic as emotionally laden as dating habits. Where there are teen-agers these difficulties arise just as naturally as the sun rises. The working out of these difficulties is the price that families have to pay to help their young achieve an understanding of their roles as men and women in the American cultural scene.

FAMILY LIVING EDUCATION: EDUCATION FOR MENTAL HEALTH

THEODORE ANDERSON, M.D.

My business is mental health and your business is education. Today, I would like to tell you something about why your business is my business and why my business is yours.

In the mental health world we have some new ideas and theories about treatment of mental illness, and we think we are getting somewhere with them. We are not sure whether these will work out because they are very difficult to test out. But I want to share with you some of these ideas. The theories have something to do with reducing the probability that people will develop disabling mental illnesses and with reducing the probability that children and adults who are mentally retarded will be disabled by retardation.

Our theories are based on the following ideas: in the normal course of human events each one of us experiences major crises at various points in our lives; these crises can generally be classified as being accidental or natural. For example, an accidental crisis might be a broken leg, an illness, a house's burning down, the stock market crash, or any other event which is relatively unlikely. A natural crisis is one which, under ordinary conditions, most of us can count on experiencing. These "life" crises are events such as birth, weaning, toilet training, leaving home to go to school, puberty, adolescent independence, marriage, birth of the first child, death of parents, child goes to school, youngest (or last) child leaves home, death of spouse, and so on. Each of these events will occur in the lives of most of us. Each event creates its own crisis. This crisis need not be associated with a sense of alarm, of course, but it does require rather prompt redefinition of our relationships with others and a reassessment of ourselves.

Now crises per se are not bad at all. Crises are usually periods of rapid growth. Growth takes place in the process of getting into a crisis and somehow getting through it. No one is very clear about the process by which crises lead to rapid growth, although this is the usual experience of us all. But crises can also be disorganizing experiences. Many of us have had crises which have taken days, months, and sometimes years to get over. And even then emotional residues may remain. When these residues are prominent or when they increase in severity, we observe the phenomenon that we so frequently call emotional illness or mental illness.

Mental illness is apparently caused by the interaction of a number of factors. These include hereditary, biological, psychological, and social factors. It is this last group, the social factors, which we think we can alter. If these relationships of man to his environment can be altered,

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possibly some mental illness can be prevented. Possibly crises can become growth experiences more often if the individual and his surrounding environment are optionally prepared.

Today we are going to talk about sex and family living education. This is important for the following reasons. We are not completely sure, but we think that preparation for a crisis increases the chances of the crisis leading to a growth experience. What kinds of preparation can sex and family living education provide?

First, it can provide information about biological and physiological aspects of the sexual functions of the human body. You know, as a rule, certain biological characteristics are predictable and inevitable. You teach all about these in your classes. In addition, of course, certain emotional experiences develop along with biological changes and are also predictable within certain limits.

We can predict that at about a certain age a girl will begin to menstruate. We can also predict that she will form certain ideas and attitudes linked to the physiological changes. Her ideas and attitudes will resonate with the attitudes of her parents, her peers, her school, and the various other aspects of her relevant world. She will learn that her body is preparing itself for the child bearing process. She will also hear that menstruation is "the curse." Now, a girl has to deal with the idea as well as with the physiological change. She may accept an idea, modify it, or reject it, but she will not be able to grow up in a world in which the idea does not occur to her. This can be guaranteed. Can she be prepared for these inevitable ideas and attitudes that she is going to have presented to her?

What are these ideas? You know what they are because you have talked with a number of girls. Out of your aggregate experience you recognize patterns that are shared by most girls. You also recognize that fathers, boyfriends, and other males have ideas and attitudes about menstruation, of course, and so you do not limit your attention to only one sex. So you can help people entering this stage of life by explaining ahead of time the physiological changes and attitudes and ideas that will come together.

There are, of course, other examples we could use to illustrate the same point. A family has learned, through the years, to live together and care for each other. Finally the last child (usually the youngest, but not always so) is ready to leave home. The parents are faced with an "empty" house. What this means, of course, is that they have only each other to talk to. Again, a major family reorganization is called for. This is a period of potential rapid growth; it is a time of crisis. Each member of the family will be experiencing certain feelings at this time. They may be important or unimportant, but these feelings will be present, and the family will have to deal with them somehow.

There is one other way in which you as teachers are helping us. You are participating in changing the community. And I do not necessarily

mean just changing others. By being here today and talking about this subject, we are all gradually changing the ways in which we relate to each other.

Let us take a step back from this idea so it will become more clear. In this room are gathered a wide variety of people with a wide variety of ideas about the subjects under discussion. It turns out that parents, teachers, and those concerned with morals and laws are not of one mind about sex and family living education. Furthermore, these subjects often generate considerable concern and other strong feelings in us. Long before such educational classes are opened for children, adults will gather in such meetings as this to share their views. In brief, the issues of sex education and family living education provide adults the opportunity to form strong personal opinions, to come together with others holding equally strong but divergent opinions, and in the encounter, to work toward living with each other.

I shall give you an example of what I mean. A friend of mine, a psychiatrist, was recently involved in producing an extensive television series on sex education. He very simply tried to present the facts of human growth and development. He discussed and illustrated on the television video tape the anatomical, physiological, and emotional changes which occur in the process of growing up. He carefully screened out of his presentation all moral judgments, indicating that he left these issues to the children, parents, and others to work out for themselves.

However, a very vocal group of citizens emerged who felt that the films were inaccurate (not immoral, mind you). They said, "Sex and family living are intertwined with a moral and religious system and to present this information out of this religious context is to present misinformation. In substance, and in content, the information presented is inaccurate!" He and many others were indeed surprised to learn of this differing opinion. Let me emphasize again that this dissenting group was not arguing that his presentation was bad because it was immoral, but rather that it was inaccurate.

A marvelous thing then happened in the community. Several vocal groups met to discuss this television program and to plan for its use. They came together in the press, in public meetings and in other settings. In full view of the whole community they set about working out their differences. Recall that I am now not talking about sex education. I am talking about the gift to the community these concerned citizens were making by openly expressing and confronting each other with divergent views. The whole community entered with them into the crisis.

Many of you have had similar experiences I would guess. If you have tried to establish a sex education program, you have met others with strong opinions differing from yours. And you have worked together with these opponents to arrive at a better way to live together. Regardless of whether your programs have themselves been successes or failures in your eyes, this work you have done has profited the community.

Today, we are going to hear different stories by people who have been in such conflict situations. My guess is that you will be satisfied that you understand how their unique crises arose in their programs. You will probably not be as satisfied with their accounts of how the crises were resolved. In some cases you really won't know what significant events happened to bring about conflict resolution. The author of the account, however, may not either, for this is the nature of conflict resolution. A successful resolution will contain solutions not available before the crisis, and no one will be quite sure where they came from.

This is one part of the work of all of you. It is where your work very significantly affects the work that we are trying to do. To the degree that you are successful, we will be successful, we think; to the degree that you are not, we will also not be. Your work is also of crucial importance to many community care-giving workers in addition to the mental health professionals. I am not talking about your effect on people who are patients. I am not talking about your participation in treatment. I am talking about reducing the probability of people's becoming disabled by the crises that are absolutely inevitable in their lives. By turning these crises into healthy, growing experiences, you are helping us.